

Case Number:	CM14-0008781		
Date Assigned:	02/12/2014	Date of Injury:	05/19/2001
Decision Date:	08/14/2014	UR Denial Date:	12/24/2013
Priority:	Standard	Application Received:	01/22/2014

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Orthopedic Surgery and is licensed to practice in Texas. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 49 year old female injured on 05/19/01 due to undisclosed mechanism of injury. Current diagnoses included chronic back pain status post two level posterior lumbar interbody fusion, status post removal of hardware, anxiety/depression, right hip trochanteric bursitis, and morbid obesity. The injured worker complained of increasing aching low back pain rated at 7/10 radiating to the left lower extremity. The injured worker also reported left knee was having increased symptomology and secondary antalgic gait. The injured worker utilized Omeprazole, Alprazolam, Gabapentin, Codeine, Tramadol, and Naproxen for medication management. Physical examination revealed significant reduced range of motion, severe tenderness to palpation under the lumbar paraspinal muscles, sciatic stretch, and straight leg raise positive on the right, left knee flexion and extension decreased, medial and lateral joint tenderness, and McMurray's sign positive. The injured worker received intramuscular injections consisting of 16mg of Toradol and vitamin B12. Documentation indicated the injured worker had previously received physical therapy. Initial request for eight physical therapy for the lumbar spine, Naproxen 500mg #60 with three refills, Hydrocodone/acetaminophen 10-325mg #90 with three refills, Omeprazole 20mg #60 with three refills, TG Ice 8/10/2/2% 80g, intramuscular injections of Toradol 30mg and Vitamin B12 complex 1000mcg was initially non-certified on 12/26/13.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

8 PHYSICAL THERAPY FOR THE LUMBAR SPINE: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines PHYSICAL MEDICINE Page(s): 98.

Decision rationale: As noted on page 98 of the Chronic Pain Medical Treatment Guidelines, current guidelines recommend 9 visits over 8 weeks for the treatment of lumbago and allow for fading of treatment frequency (from up to 3 or more visits per week to 1 or less), plus active self-directed home physical therapy. The documentation indicated the injured worker has previously undergone post-operative physical therapy; however, it has been a significant amount of time since completion. However, the documentation lacked evidence of acute injury or objective findings to indicate a significant worsening in the patient's status. As such the request for 8 physical therapy for the lumbar spine cannot be recommended as medically necessary.

NAPROXYN 500MG #60 WITH 3 REFILLS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NON-STEROIDAL ANTI-INFLAMMATORY DRUGS.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, SPECIFIC DRUG LIST & ADVERSE EFFECTS Page(s): 70.

Decision rationale: As noted on page 70 of the Chronic Pain Medical Treatment Guidelines, non steroidal anti-inflammatory medications (NSAIDs) are recommended as a second-line treatment after acetaminophen for acute exacerbations of chronic pain. In general, there is conflicting evidence that non steroidal anti-inflammatory medications (NSAIDs) are more effective than acetaminophen for acute lower back pain. Package inserts for NSAIDs recommend periodic lab monitoring of a complete blood count (CBC) and chemistry profile (including liver and renal function tests). There is no documentation that these monitoring recommendations have been performed and the injured worker is being monitored on a routine basis. Additionally, it is generally recommended that the lowest effective dose be used for all NSAIDs for the shortest duration of time. As such, the request for Naproxyn 500mg #60 with 3 refills cannot be established as medically necessary.

HYDROCODONE/APAP 10/325MG #90 WITH 3 REFILLS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS FOR CHRONIC PAIN.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS, CRITERIA FOR USE Page(s): 77.

Decision rationale: As noted on page 77 of the Chronic Pain Medical Treatment Guidelines, patients must demonstrate functional improvement in addition to appropriate documentation of

ongoing pain relief to warrant the continued use of narcotic medications. There is no clear documentation regarding the functional benefits or any substantial functional improvement obtained with the continued use of narcotic medications. In addition, no recent opioid risk assessments regarding possible dependence or diversion were available for review. As the clinical documentation provided for review does not support an appropriate evaluation for the continued use of narcotics as well as establish the efficacy of narcotics, the medical necessity of hydrocodone/apap 10/325mg #90 with three refills cannot be established at this time.

OMEPROZOLE 20MG #60 WITH 3 REFILLS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI SYMPTOMS AND CARDIOVASCULAR RISK.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Proton Pump.

Decision rationale: As noted in the Official Disability Guidelines - Online version, Pain Chapter, proton pump inhibitors are indicated for patients at intermediate and high risk for gastrointestinal events with concurrent use of non-steroidal anti-inflammatory drug use. Risk factors for gastrointestinal events include age greater than 65 years; history of peptic ulcer, gastrointestinal (GI) bleeding or perforation; concurrent use of ASA, corticosteroids, and/or an anticoagulant; or high dose/multiple non steroidal anti-inflammatory medications (NSAIDs) (e.g., NSAID + low-dose ASA). There is no indication that the injured worker is at risk for gastrointestinal events requiring the use of proton pump inhibitors. Furthermore, long-term PPI use (> 1 year) has been shown to increase the risk of hip fracture. As such, the request for Omeprazole 20mg #60 with three refills cannot be established as medically necessary.

TGICE 8/10/2/2% 80 GRAMS:

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL ANALGESICS.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111.

Decision rationale: As noted on page 111 of the Chronic Pain Medical Treatment Guidelines, the safety and efficacy of compounded medications has not been established through rigorous clinical trials. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is no indication in the documentation that these types of medications have been trialed and/or failed. Further, there is no indication the injured worker cannot utilize the readily available over-the-counter formulation of this medication. Therefore, TGIce 8/10/2/2% 80 grams cannot be recommended as medically necessary as it does not meet established and accepted medical guidelines.

INTRAMUSCULAR INJECTIONS TORADOL 30MG: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CHRONIC PAIN MEDICAL TREATMENT GUIDELINES NSAIDS, SPECIFIC DRUG LIST & ADVERSE EFFECTS Page(s): 72.

Decision rationale: As noted on page 72 of the Chronic Pain Medical Treatment Guidelines, Toradol is not indicated for minor or chronic painful conditions. There is no indication in the documentation provided that the injured worker was being treated for an acute injury. As such, the request for intramuscular injections Toradol 30mg cannot be recommended as medically necessary.

VITAMIN B12 COMPLEX 1000MCG: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) PAIN (CHRONIC), VITAMIN B.

Decision rationale: As noted in the Pain chapter of the Official Disability Guidelines, vitamin B is not recommended. Vitamin B is frequently used for treating peripheral neuropathy but its efficacy is not clear. As such, the request for Vitamin B12 Complex 1000MCG cannot be recommended as medically necessary at this time.