

Case Number:	CM14-0009735		
Date Assigned:	02/21/2014	Date of Injury:	08/30/2007
Decision Date:	07/29/2014	UR Denial Date:	01/06/2014
Priority:	Standard	Application Received:	01/23/2014

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 Emergency Medicine and is licensed to practice in California. 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 patient is a 34-year-old male who was injured on August 30, 2007. The patient continued to experience pain in his lower back. Physical examination was notable for exquisite paraspinal tenderness, positive straight leg raise bilaterally, and decreased sensation at the bilateral thighs and bilateral gastrocnemius muscles. MRI of the lumbar spine dated April 13, 2013 was read as lumbar spondylosis with mild disc protrusions at L4-5 and L5-S1 with no significant spinal or neuroforaminal stenoses. Diagnosis was multilevel lumbar spine disc bulging. The treatment included back brace and medications. Requests for authorization for Demerol 50 mg, Phenergan 50 mg, Toradol 60 mg, Dexamethasone 10 mg, Depo-medrol 80 mg, Percocet, Norco 10/325, and Motrin 800 mg were submitted for consideration.

IMR ISSUES, DECISIONS AND RATIONALES

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

DEMEROL 50: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Meperidine and Opioids Page(s): 61, 74-96.

Decision rationale: Demerol is Meperidine, a opioid analgesic, similar to morphine. Chronic Pain Medical Treatment Guidelines state that opioids are not recommended as a first line therapy. Opioid should be part of a treatment plan specific for the patient and should follow criteria for use. Criteria for use include establishment of a treatment plan, determination if pain is nociceptive or neuropathic, failure of pain relief with non-opioid analgesics, setting of specific functional goals, and opioid contract with agreement for random drug testing. If analgesia is not obtained, opioids should be discontinued. The patient should be screened for likelihood that he or she could be weaned from the opioids if there is no improvement in pain of function. It is recommended for short term use if first-line options, such as acetaminophen or NSAIDS have failed. In this case the medication was not prescribed for short term use and the criteria for opioid use were not met. Meperidine is not recommended for chronic pain control. Therefore the request is not medically necessary.

PHENERGAN 50MG: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment 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, Antiemetics (For Opioid Nausea).

Decision rationale: Phenergan is promethazine, an antiemetic medication. Antiemetics are not recommended for nausea and vomiting secondary to chronic opioid use. Nausea and vomiting is common with use of opioids. These side effects tend to diminish over days to weeks of continued exposure. Promethazine is recommended as a sedative and antiemetic in pre-operative and post-operative situations. Multiple central nervous system effects are noted with use including somnolence, confusion and sedation. Tardive dyskinesia is also associated with use. Anticholinergic effects can occur (dry mouth, dry eyes, urinary retention and ileus). This medication is not recommended. Therefore the request is not medically necessary.

TORADOL 60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-68, 72.

Decision rationale: Toradol is Ketorolac, a non-steroidal anti-inflammatory drug (NSAID). Chronic Medical Treatment Guidelines state that "anti-inflammatory drugs are the traditional first line of treatment, but long term use may not be warranted". For osteoarthritis it was recommended that the lowest dose for the shortest length of time be used. It was not shown to be more effective than acetaminophen, and had more adverse side effects. Adverse effects for GI toxicity and renal function have been reported. Medications for chronic pain usually provide temporary relief. Medications should be prescribed only one at a time and should show effect

within 1-3 days. Record of pain and function with the medication should be recorded. Ketorolac is not indicated for minor or chronic painful conditions. Therefore the request is not medically necessary.

DEXAMETHASONE 10MG: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic, Corticosteroids (Oral/Parenteral/IM for Low Back Pain).

Decision rationale: Dexamethasone is a corticosteroid medication. Corticosteroid medications are recommended for acute radicular pain, and patients should be aware that research provides limited evidence of effect with this medication. They are not recommended for acute non-radicular pain (i.e. axial pain) or chronic pain. In this case there is no documentation that the patient is suffering from acute radicular pain. The patient's pain was chronic. The medication is therefore, not recommended. Therefore the request is not medically necessary.

DEPO-MEDROL 80MG: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic, Corticosteroids (Oral/Parenteral/IM for Low Back Pain).

Decision rationale: Depo-Medrol is a corticosteroid medication. Corticosteroid medications are recommended for acute radicular pain, and patients should be aware that research provides limited evidence of effect with this medication. They are not recommended for acute non-radicular pain (i.e. axial pain) or chronic pain. In this case there is no documentation that the patient is suffering from acute radicular pain. The patient's pain was chronic. The medication is therefore, not recommended. Therefore the request is not medically necessary.

PERCOCET: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Acetaminophen, and Opioids Page(s): 11, 74-96.

Decision rationale: Percocet 10/325 is compounded medication containing Oxycodone/acetaminophen. Chronic Pain Medical Treatment Guidelines state that opioids are

not recommended as a first line therapy. Opioid should be part of a treatment plan specific for the patient and should follow criteria for use. Criteria for use include establishment of a treatment plan, determination if pain is nociceptive or neuropathic, failure of pain relief with non-opioid analgesics, setting of specific functional goals, and opioid contract with agreement for random drug testing. If analgesia is not obtained, opioids should be discontinued. The patient should be screened for likelihood that he or she could be weaned from the opioids if there is no improvement in pain of function. It is recommended for short term use if first-line options, such as acetaminophen or NSAIDS have failed. Acetaminophen is recommended for treatment of chronic pain & acute exacerbations of chronic pain. Acetaminophen overdose is a well-known cause of acute liver failure. Hepatotoxicity from therapeutic doses is unusual. Renal insufficiency occurs in 1 to 2% of patients with overdose. The recommended dose for mild to moderate pain is 650 to 1000 mg orally every 4 hours with a maximum of 4 g/day. In this case there is no documentation that the patient had been using opioid medications since at least January 2013. There is no documentation that the patient had signed an opioid contract or was participating in urine drug testing. Criteria for long-term opioid use have not been met. Therefore the request is not medically necessary.

NORCO 10-325 MG: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96.

Decision rationale: Norco is the compounded medication containing Hydrocodone and acetaminophen. Chronic Pain Medical Treatment Guidelines state that opioids are not recommended as a first line therapy. Opioid should be part of a treatment plan specific for the patient and should follow criteria for use. Criteria for use include establishment of a treatment plan, determination if pain is nociceptive or neuropathic, failure of pain relief with non-opioid analgesics, setting of specific functional goals, and opioid contract with agreement for random drug testing. If analgesia is not obtained, opioids should be discontinued. The patient should be screened for likelihood that he or she could be weaned from the opioids if there is no improvement in pain of function. It is recommended for short term use if first-line options, such as acetaminophen or NSAIDS have failed. Acetaminophen is recommended for treatment of chronic pain & acute exacerbations of chronic pain. Acetaminophen overdose is a well-known cause of acute liver failure. Hepatotoxicity from therapeutic doses is unusual. Renal insufficiency occurs in 1 to 2% of patients with overdose. The recommended dose for mild to moderate pain is 650 to 1000 mg orally every 4 hours with a maximum of 4 g/day. In this case there is no documentation that the patient had been using opioid medications since at least January 2013. There is no documentation that the patient had signed an opioid contract or was participating in urine drug testing. Criteria for long-term opioid use have not been met. Therefore the request is not medically necessary.

MOTRIN 800 MG: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-68, 72.

Decision rationale: Motrin is ibuprofen, a non-steroidal anti-inflammatory drug (NSAID). Chronic Medical Treatment Guidelines state that "anti-inflammatory drugs are the traditional first line of treatment, but long term use may not be warranted". For osteoarthritis it was recommended that the lowest dose for the shortest length of time be used. It was not shown to be more effective than acetaminophen, and had more adverse side effects. Adverse effects for GI toxicity and renal function have been reported. Medications for chronic pain usually provide temporary relief. Medications should be prescribed only one at a time and should show effect within 1-3 days. Record of pain and function with the medication should be recorded. In this case the patient had been receiving the medication since at least January 2013. The patient was not obtaining analgesia. The risk of adverse effects increases with duration. Therefore the request is not medically necessary.