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| Case Number: | CM14-0105503 | | |
| Date Assigned: | 09/12/2014 | Date of Injury: | 05/01/2003 |
| Decision Date: | 10/24/2014 | UR Denial Date: | 06/17/2014 |
| Priority: | Standard | Application Received: | 07/08/2014 |

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 Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in Nevada and 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 injured worker is a 45 year old male who had a work related injury on 05/01/03. There was no mechanism of injury documented. Most recent clinical documentation submitted for review was dated 06/04/14. The injured worker continued to complain of neck pain. The injured worker had difficulty sleeping at night. The pain radiated to his shoulders. The injured worker had relief in his pain when he was in acupuncture. However had not yet been approved he stated his whole body felt tired. The injured worker saw the urologist for hematuria but the report was not available. Physical examination revealed spasm and pain and decreased range of motion of the cervical spine. There was facet tenderness. There was crepitation with movement. Pain with axial compression. Exam of the lumbar spine revealed spasm, painful range of motion, and limited range of motion. Lasegue and straight leg raise to 60 degrees positive bilaterally. Sensation decreased bilaterally at L5-S1 distribution. Pain bilaterally at L5-S1 distribution. Strength rated 5/5 in lower extremities to manual motor testing. Diagnosis chronic low back pain. Lumbar spine degenerative disc disease. Thoracic spine sprain/strain. Cervical spine degenerative disc disease. Chronic neck pain. Prior utilization review on 06/17/14 was non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 prescription of Ultram ER 150mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for Use of Opioids 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. There are no documented VAS pain scores for this patient with or without 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 this medication cannot be established at this time.

1 prescription of Duexis #90: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain (Chronic)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Other Medical Treatment Guideline or Medical Evidence: <http://www.rxlist.com/duexis-drug/indications-dosage.htm>

Decision rationale: Based on review of the medical records provided the request for Duexis #90 is not supported as medically necessary. Current guidelines indicate the prescription combination of ibuprofen and famotidine is not recommended as a first-line drug treatment when both components of Duexis are readily available with over-the-counter formulations in multiple strengths and variations. With less benefit and higher cost, it is difficult to justify using Duexis as a first-line therapy. Additionally, there's no discussion in the documentation regarding the necessity of proton pump inhibitors. As such, the request for Duexis #90 cannot be recommended as medically necessary at this time.

1 prescription of Flector patch 1.3%: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain (Chronic)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ODG) Pain (Chronic), Flector patch.

Decision rationale: As noted in the Pain chapter of the Official Disability Guidelines, Flector patches are not recommended as a first-line treatment. Topical diclofenac is recommended for osteoarthritis after failure of an oral NSAID or contraindications to oral NSAIDs, after considering the increased risk profile with diclofenac, including topical formulations. Flector patch is FDA indicated for acute strains, sprains, and contusions. Physicians should measure transaminases periodically in patients receiving long-term therapy with diclofenac. There is no indication that this monitoring has occurred. The efficacy in clinical trials for topical NSAIDs has been inconsistent and most studies are small and of short duration. In addition, there is no data that substantiate Flector efficacy beyond two weeks. As such the request for this medication cannot be recommended as medically necessary at this time.

1 complete spinal decompression on the DRX 9000 machine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

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 chapter, Vertebral axial decompression (VAX-DÂ®)

Decision rationale: The request for complete spinal decompression on the DRX 9000 machine is not medically necessary. Not recommended. While there are some limited promising studies, the evidence in support of powered traction devices in general, and specifically vertebral axial decompression, is insufficient to support its use in low back injuries. Vertebral axial decompression for treatment of low back injuries is not recommended. Therapy may also have risks, including the potential to cause sudden deterioration requiring urgent surgical intervention. As such, medical necessity has not been established.