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| Case Number: | CM14-0105617 | | |
| Date Assigned: | 08/08/2014 | Date of Injury: | 03/01/2010 |
| Decision Date: | 10/01/2014 | UR Denial Date: | 07/03/2014 |
| 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 Physical Medicine & Rehabilitation, and is licensed to practice in Texas & Oklahoma. 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 47-year-old female who reported an injury on 03/01/2010. The mechanism of injury was not provided for clinical review. The diagnoses included brachial neuritis or radiculitis and lumbar radiculopathy. The previous treatments included medication. Within the clinical note dated 06/24/2014 it was reported the injured worker complained of lower back pain and bilateral arm pain. Upon the physical examination, the provider noted the paravertebral muscles were tender, with spasms present. The range of motion was restricted. Sensation was reduced in the bilateral median nerve distribution. The lumbar spine was tender with spasms present. The range of motion was restricted with a positive straight leg raise bilaterally. The provider requested Medrox ointment for pain relief, omeprazole, naproxen, hydrocodone, zolpidem, and cyclobenzaprine. However, a rationale was not provided for clinical review. The Request for Authorization was provided and dated 06/24/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Medrox Ointment: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics. Decision based on Non-MTUS Citation <http://www.drugs.com/pro/medrox-rx-ointment.html>

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical NSAIDs Page(s): 111-112.

Decision rationale: The California MTUS Guidelines note topical NSAIDs are recommended for osteoarthritis and tendinitis, in particular that of the knee and/or elbow and other joints that are amenable. Topical NSAIDs are recommended for short term treatment of 4 to 12 weeks. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency and dosage of the medication. The request submitted failed to provide the treatment site. Therefore, the request is not medically necessary.

Omeprazole 20mg #30 with 2 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines GI symptoms & cardiovascular risk Page(s): 68-69.

Decision rationale: The California MTUS Guidelines note proton pump inhibitors such as omeprazole are recommended for injured workers at risk for gastrointestinal events and/or cardiovascular disease. The risk factors for gastrointestinal events include over the age of 65, a history of peptic ulcer, gastrointestinal bleed or perforation, use of corticosteroids and/or anticoagulants. In the absence of risk factors for gastrointestinal bleed and events, proton pump inhibitors are not indicated when taking NSAIDs. The treatment of dyspepsia from NSAID usage includes stopping the NSAID, switching to a different NSAID, or adding an H2 receptor antagonist or proton pump inhibitor. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. Additionally, there is lack of clinical documentation indicating the injured worker had a diagnosis of dyspepsia secondary to NSAID therapy. Therefore, the request is not medically necessary.

Naproxen Sodium 550mg #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Naproxen Page(s): 66-67.

Decision rationale: The California MTUS Guidelines note naproxen is a non-steroidal anti-inflammatory drug for the relief of the signs and symptoms of osteoarthritis. The guidelines recommend naproxen at the lowest dose for the shortest period of time in patients with moderate to severe pain. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. Therefore, the request is not medically necessary.

Hydrocodone APAP 10/325mg #120 with 2 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use, On-Going Management Page(s): 78.

Decision rationale: The California MTUS Guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The guidelines recommend the use of a urine drug screen or inpatient treatment with issues of abuse, addiction, or poor pain control. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. The provider failed to document an adequate and complete pain assessment within the documentation. Additionally, the use of a urine drug screen was not provided for clinical review. Therefore, the request is not medically necessary.

Zolpidem Tartrate 10mg #30: 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)- Ambien, Stress and mental illness

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

Decision rationale: The Official Disability Guidelines note zolpidem is a prescription short acting nonbenzodiazepine hypnotic, which was approved for short term, usually 2 to 6 week treatment of insomnia. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. There is lack of documentation indicating the injured worker is treated for or diagnosed with insomnia. The request submitted failed to provide the frequency of the medication. Therefore, the request is not medically necessary.

Cyclobenzaprine Hcl 10mg #60 with 5 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63, 64.

Decision rationale: The California MTUS Guidelines recommend non-sedating muscle relaxants with caution as a second line option for short term treatment of acute exacerbation in patients with chronic low back pain. The guidelines note the medication is not recommended for longer than 2 to 3 weeks. There is lack of documentation indicating the efficacy of the

medication as evidenced by significant functional improvement. The injured worker has been utilizing the medication since at least 06/2014, which exceeds the guidelines recommendation of short term use of 2 to 3 weeks. The request submitted failed to provide the frequency of the medication. Therefore, the request is not medically necessary.