

Case Number:	CM14-0105854		
Date Assigned:	07/30/2014	Date of Injury:	02/10/2001
Decision Date:	09/03/2014	UR Denial Date:	06/17/2014
Priority:	Standard	Application Received:	07/09/2014

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 and Rehabilitation and is licensed to practice in Texas and 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 62-year-old male who reported an injury on 02/10/2001. The mechanism of injury was not provided for review. The injured worker ultimately underwent lumbar laminectomy surgery. It was noted that the injured worker developed chronic low back pain that was managed with medications. The injured worker was monitored for aberrant behavior with urine drug screens that were regularly consistent. The physical findings included diffuse tenderness to palpation of the lumbar paraspinal musculature with moderate spasm and moderate facet tenderness in the bilateral lower lumbar spine with a positive sacroiliac joint test bilaterally, positive Faber/Patrick's test bilaterally and a positive Yeoman's test bilaterally. It was also noted that the injured worker had a positive straight leg raising test at 50 degrees bilaterally with 4/5 motor strength in the bilateral lower extremities. The injured worker's medications included Vicodin 5/325 mg, tramadol 50 mg, ibuprofen 800 mg, Nexium 40 mg, Flexeril 10 mg. It was noted that the injured worker had a 7/10 pain level that was exacerbated by prolonged activity. It was noted that the injured worker had a positive response to medications and requested a 3 month supply due to cost. The injured worker's diagnoses included status post lumbar laminectomy, lumbar radiculopathy, lumbar discopathy, lumbar pain/strain, intractable low back pain and sacroiliac joint pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

Vicodin 5/325 mg sig one po bid #60: Upheld

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

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

Decision rationale: The requested Vicodin 5/325 mg #60 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends ongoing use of opioids be supported by documented functional benefit, a quantitative assessment of pain relief, managed side effects and evidence that the injured worker is monitored for aberrant behavior. The clinical documentation does indicate that the injured worker is monitored for aberrant behavior and has functional benefit without significant side effects resulting from medication usage. However, the clinical documentation does not adequately assess the injured worker's pain relief related to medication usage. It is noted that the injured worker has 7/10 pain; however, there is no documentation of a reduction in pain after medication usage. As such, the requested Vicodin 5/325 mg #60 is not medically necessary or appropriate.

Nexium 40 mg #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.

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

Decision rationale: The requested Nexium 40 mg #90 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends the ongoing use of the medication be based on significant risk factors of gastrointestinal disturbances due to medication usage. The clinical documentation indicates that the injured worker has been on this since at least 10/2013. The most recent evaluation does not provide an adequate assessment of the injured worker's gastrointestinal system to indicate that they are at continued risk for development of gastrointestinal disturbances related to medication usage. Furthermore, the request, as it is submitted, does not clearly identify a frequency of treatment. In the absence of this information the appropriateness of the request itself cannot be determined. As such, the requested Nexium 40 mg #90 is not medically necessary or appropriate.

Flexaril 10 mg #180: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63.

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

Decision rationale: The requested Flexeril 10 mg #180 is not medically necessary or appropriate. The clinical documentation submitted for review does indicate that the injured

worker has been on this medication since at least 10/2013. California Medical Treatment Utilization Schedule does not recommend muscle relaxants in the management of chronic pain and that the use of muscle relaxants be limited to a duration of 2 to 3 weeks for acute exacerbations of chronic pain. As the injured worker has been on this medication for a duration to exceed guideline recommendations, continued use would not be supported. Furthermore, the request, as it is submitted, does not clearly identify a frequency of treatment. In the absence of this information the appropriateness of the request itself cannot be determined. As such, the requested Flexeril 10 mg #180 is not medically necessary or appropriate.

Qualaquin 325 mg #90: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation
FDA<http://www.fda.gov/downloads/Drugs/DrugSafety/UCM192698.pdf>.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: FDA.gov.

Decision rationale: The requested Qualaquin 325 mg #90 is not medically necessary or appropriate. The clinical documentation submitted for review does indicate that the injured worker has been on this medication since at least 10/2013. California Medical Treatment Utilization Schedule and Official Disability Guidelines do not address this medication. FDA.gov indicates that this medication is approved for usage to treat some signs and symptoms related to malaria. The clinical documentation submitted for review does not provide any evidence that the injured worker has or has ever suffered from malaria. Therefore, the need for this medication is not clearly justified within the documentation. As such, the requested Qualaquin 325 mg #90 is not medically necessary or appropriate.