

Case Number:	CM14-0019983		
Date Assigned:	04/28/2014	Date of Injury:	06/22/2010
Decision Date:	07/08/2014	UR Denial Date:	02/13/2014
Priority:	Standard	Application Received:	02/18/2014

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 has a subspecialty in Pain Medicine 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 44 year old male injured on 06/22/10 when he slipped and fell during a foot pursuit resulting in right wrist and shoulder pain. The injured worker was treated with physical therapy, injection, medication management, and eventual right shoulder surgery. On 06/14/11 the injured worker was injured during interaction with a felon resulting in right hand injury and treated with bracing, physical therapy, and eventual right hand surgery with no benefit. The injured worker underwent lumbar epidural steroid injections for low back pain without improvement in symptoms and ongoing medication management. Current diagnoses included lumbar/lumbosacral disc degeneration and thoracic/lumbosacral neuritis/radiculitis. Clinical note dated 01/18/14 indicated the injured worker presented complaining of low back and right buttock pain with associated spasms. The injured worker rated his pain at 5/10 on average with utilizing of anti-inflammatory medications for pain relief. The injured worker has continued to reduce intake of opiates and has essentially discontinued opiate use. The injured worker reported feeling less anxious and depressed and was actively working on weight loss. Physical examination revealed evidence of right paralumbar hypertonus and elevated hip height on the right with flattening of the lumbar lordotic curve, asymmetrical curvature to the right lumbar spine due to right paraspinous hypertonus and spasming. The initial request for Norco 10/325mg #4, Percocet 10/325mg #4, Oxaprozin 600mg #4, and Lidocaine 5% Ointment #4 was non-certified on 02/13/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

NORCO 10/325MG #4: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines WHEN TO CONTINUE OPIOIDS Page(s): 79, 80, 81.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 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. Additionally, the clinical documentation indicates the injured worker has weaned from opioid medications and is utilizing anti-inflammatories for pain management. As such, the request for Norco 10/325mg #4 cannot be recommended as medically necessary.

PERCOCET 10/325MG #4: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines WHEN TO CONTINUE OPIOIDS Page(s): 79, 80, 81.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 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. Additionally, the clinical documentation indicates the injured worker weaned off of opioid medications and is utilizing anti-inflammatories for pain management. As such, the request for Percocet 10/325mg #4 cannot be recommend as medically necessary.

LIDOCAINE 5% OINTMENT #4: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL ANALGESICS Page(s): 112.

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. Lidoderm is recommended for a trial if there is evidence of localized pain that is consistent with a neuropathic etiology. There should be evidence of a trial of first-line

neuropathy medications (tri-cyclic or SNRI anti-depressants or anticonvulsants such as gabapentin or Lyrica). Lidoderm is not generally recommended for treatment of osteoarthritis or treatment of myofascial pain/trigger points. Therefore Lidocaine 5% Ointment #4 cannot be recommended as medically necessary as it does not meet established and accepted medical guidelines.

OXAPROZIN 600MG #4: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ANTI-INFLAMMATORY MEDICATIONS Page(s): 22.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 70.

Decision rationale: As noted on page 70 of the Chronic Pain Medical Treatment Guidelines, on-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 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. Additionally, if deemed necessary, there is no indication that the injured worker cannot utilize over-the-counter anti-inflammatories for acute pain. As such, the request for Oxaprozin 600mg #4 cannot be established as medically necessary.