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| Case Number: | CM14-0137174 | | |
| Date Assigned: | 09/05/2014 | Date of Injury: | 05/18/2009 |
| Decision Date: | 10/09/2014 | UR Denial Date: | 08/04/2014 |
| Priority: | Standard | Application Received: | 08/25/2014 |

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 and Ohio. 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 35-year-old female who reported an injury on 05/18/2009. The mechanism of injury was a fall. She is diagnosed with lumbar radiculopathy, lumbar disc displacement, low back pain, sacroiliitis, and fibromyalgia. Her past treatments have included physical therapy, epidural steroid injections, use of a lumbar support, aquatic therapy, SI joint injections, psychotherapy, and medications. A urine drug screen was performed on 05/08/2014 and was noted to reveal evidence of cyclobenzaprine, gabapentin, hydrocodone, and hydromorphone. It was noted that gabapentin and hydrocodone were consistent with her prescription medication list, but cyclobenzaprine and hydromorphone were inconsistent as they were not reported as prescribed. On 07/15/2014, the injured worker presented with complaints of low back pain with radiation into the bilateral lower extremities. It was noted that her pain level had not improved with treatment. She also reported numbness, tingling, mild edema, leg cramping, and spasm. It was noted that she reported increased ability to perform her activities of daily living with use of her medications. She rated her pain 7/10 to 8/10. Her medications were noted to include Anaprox, tizanidine, Norco, Prilosec, Neurontin, and Percocet. The treatment plan included medication refills, with requests for omeprazole 20 mg #30; cyclobenzaprine 7.5 mg #90; Percocet 10/325 mg #90; tizanidine 4 mg #60; and Norco 10/325 mg #120. The specific rationale for each medication was not indicated. The official Request for Authorization form was not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Omeprazole 20mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Chapter

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

Decision rationale: According to the California MTUS Chronic Pain Guidelines, proton pump inhibitors may be recommended for patients taking NSAID medications who have been found to be at increased risk for gastrointestinal events or for those taking NSAID medications who have complaints of dyspepsia. The injured worker was noted to have been utilizing Anaprox since at least 02/08/2014. A 05/08/2014 clinical note indicated that she had reported GI upset from use of NSAIDs. She was noted to have been taking omeprazole 20 mg since at least 02/08/2014. However, the documentation did not indicate that the omeprazole had been effective in controlling her GI complaints and the 05/08/2014 note indicated that a recommendation was made for her to be switched to Duexis for her NSAID and PPI therapy. Based on the lack of documentation indicating the effectiveness of omeprazole in controlling her GI complaints related to NSAID use, continued use is not supported. In addition, the submitted request failed to provide a frequency of use. For the reasons noted above, the request is not medically necessary.

Cyclobenzaprine 7.5mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Chapter

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 64.

Decision rationale: According to the California MTUS Guidelines, cyclobenzaprine may be recommended for the short term treatment of pain and muscle spasm, but there is insufficient evidence chronic use of this medication. The clinical information submitted for review failed to provide details regarding the injured worker's use of cyclobenzaprine as it was not listed with her current medications on any clinical notes submitted. However, she was noted to have cyclobenzaprine on her urine drug screens performed on 03/13/2014 and 05/08/2014 which were noted to be inconsistent with her medication list. However, clarification and explanation of these findings were not documented in the subsequent clinical notes to verify her use of cyclobenzaprine. Additionally, as she was noted to have been taking this medication as long as 03/13/2014, at which time it was revealed on her urine drug screen, continued use would not be supported as the guidelines only recommend 2 to 3 weeks of use. In addition, the submitted request failed to indicate a frequency. The request is not medically necessary.

Percocet 10/325mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 81. Decision based on Non-MTUS Citation American Pain Society & American Academy of Pain: Opioid Treatment Guidelines

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

Decision rationale: According to the California MTUS Guidelines, the ongoing use of opioid medications should be based on detailed documentation of pain relief, functional status, appropriate medication use, and adverse side effects. The clinical information submitted for review failed to include Percocet on the injured worker's medication list until her 07/15/2014 visit. However, it was not indicated that this was a new prescription at that time. Therefore, further documentation indicating the duration of use of Percocet, as well as the outcome of use with evidence of significant pain relief evidenced by numeric pain scales, in addition to her noted functional improvement with her medications. In addition, her recent urine drug screen on 05/08/2014 failed to show any evidence of oxycodone. Therefore, verification is needed that she was not utilizing this medication at this time and, if she was, documentation is needed regarding the inconsistent finding. Moreover, the submitted request did not indicate a frequency of use. For the reasons noted above, the request is not medically necessary.

Tizanidine 4mg #60:

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63-66.

Decision rationale: According to the California MTUS Guidelines, tizanidine is recommended for the management of spasticity and used off label for low back pain. The clinical information submitted for review indicated that the injured worker had been utilizing tizanidine since at least 02/08/2014. Her followup note from 07/15/2014 indicated that she reported improved function and ability to perform her activities of daily living with use of her current medications. However, she rated her pain level 7/10 to 8/10 at that visit. Therefore, there was insufficient evidence showing adequate pain relief in order to justify continued use. Furthermore, the request as submitted did not indicate a frequency of use. For the reasons noted above, the request is not medically necessary.

Norco 10/325 #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 82-86.

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

Decision rationale: According to The California MTUS Chronic Pain Guidelines, the ongoing management of patients taking opioid medication should include detailed documentation of pain relief, functional status, appropriate medication use, and adverse side effects. The injured worker was noted to have been taking Norco since at least 02/08/2014. She was noted to have evidence of hydrocodone on her urine drug screen performed on 05/08/2014; however, there was also documentation indicating that hydromorphone and cyclobenzaprine were detected, representing inconsistent results. When inconsistent results are found on urine drug screen, documentation should show a discussion and explanation regarding inconsistent results and importance of medication compliance. The documentation did not address the inconsistent urine drug screen results on 05/08/2014 and there was no other documentation indicating evidence of medication compliance. In addition, she was noted to have increased functional with her current medications at her visit on 07/15/2014. However, there was a lack of documentation adequate pain relief as she rated her pain 7/10 to 8/10 at that visit. In the absence of documentation showing a detailed pain assessment with evidence of significant pain relief and confirmation of compliance with medications, continued use of opioids is not supported. Moreover, the request failed to indicate a frequency of use. For the reasons noted above, the request is not medically necessary.