

Case Number:	CM14-0174357		
Date Assigned:	10/27/2014	Date of Injury:	08/11/2010
Decision Date:	12/08/2014	UR Denial Date:	09/11/2014
Priority:	Standard	Application Received:	10/20/2014

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 Occupational Medicine, has a subspecialty in Preventive Medicine and is licensed to practice in 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:

Injured worker (IW) is a 42 year old female who injured her left knee while working on a ladder on 08/10/10. She also developed low back pain radiating down the left leg. Per the submitted documentation, IW is s/p left knee surgery in approximately February 2014, without improvement. Other treatment has included medications, physical therapy, and injections. Her long-term medications have included Norco, Anaprox, Prilosec, and Terocin Cream. 05/28/14 Agreed Medical Evaluation (AME) report documented pain levels ranging from 5/10 to 9/10. On activities of daily living (ADL) questionnaire, IW reported that she needed help with most aspects of self-care and that she could only walk limited distances with a cane, crutches, or walker. She reported inability to sit, stand, or walk more than 30 minutes, to lift or carry anything at all, push/pull, climb stairs, or reach overhead. Future treatment recommendations included "light analgesic medication" and PT for the low back. 07/10/14 urine drug screen was positive for Hydrocodone and negative for all other substances tested. 08/14/14 office note documented 7/10 left knee pain and 9/10 left leg sciatica pain. IW reported that trigger point injection had worked for 2 weeks and back pain was increased. Treating physician stated that medications reduced pain by 50% and allowed IW to be more functional, but specific improvements in function were not documented. Left leg weakness and limited/painful range of motion of the lumbar spine and left knee were documented. 09/24/14 office note documented 8/10 low back and left leg pain and 7/10 left knee pain. IW was not currently working.

IMR ISSUES, DECISIONS AND RATIONALES

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

Anaprox 550mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 1, 67-68.

Decision rationale: For treatment of osteoarthritis, MTUS recommends use of NSAIDs at the lowest dose for the shortest period in patients with moderate to severe pain. MTUS recommends short-term use of NSAIDs for chronic low back pain or acute exacerbations of low back pain, but does not support chronic use of NSAIDs for low back conditions. Despite long-term use of Anaprox, IW continues to report pain levels of 7/10 to 8/10, which is inconsistent with treating physician's statement that medications provide 50% pain relief. Per MTUS, (f) "Functional improvement" means either a clinically significant improvement in activities of daily living or a reduction in work restrictions as measured during the history and physical exam, performed and documented as part of the evaluation and management visit billed under the Official Medical Fee Schedule (OMFS) pursuant to sections 9789.10-9789.111; and a reduction in the dependency on continued medical treatment. Per functional questionnaire in May 2014, IW reported significant deficits in essentially all ADLs. Specific functional improvements which would support continuation of the current medication regimen are not documented. Medical necessity is not established for the requested Anaprox.

Norco 10/325mg #120 with 3 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use; Opioids for chronic pain Page(s): 78-81.

Decision rationale: MTUS notes no trials of long-term opioid use for neuropathic pain. Concerning chronic back pain, MTUS states that opioid therapy "Appears to be efficacious but limited for short-term pain relief, and long-term efficacy is unclear (>16 weeks), but also appears limited. Failure to respond to a time-limited course of opioids has led to the suggestion of reassessment and consideration of alternative therapy." MTUS states monitoring of the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors) over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of controlled drugs. Despite long-term use of Norco, IW continues to report pain levels of 7/10 to 8/10, which is inconsistent with treating physician's statement that medications provide 50% pain relief. Per functional questionnaire in May 2014, IW reported significant deficits in essentially all ADLs. Specific functional improvements which would support continuation of the current medication regimen are not documented. Due to insufficient documented evidence of significant symptomatic or functional response to opioid therapy in this case, medical necessity is not established for the requested Norco 10/325.

Prilosec 20mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter: Proton pump inhibitors

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

Decision rationale: MTUS supports use of a proton pump inhibitor as a gastroprotective agent for patients on NSAID therapy who are at risk for gastrointestinal adverse events or who suffer from dyspepsia relating to NSAID therapy. Risk factors for GI events as defined by MTUS are not documented, and history of GI upset with NSAID therapy is not documented in this case. Medical necessity is not established for the requested Prilosec.

Terocin Cream 180mg #1: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: Terocin Lotion contains methyl salicylate 25%, capsaicin 0.025%, menthol 10% and lidocaine 2.50% in a lotion base for topical application. Lidoderm patch is the only form of topical lidocaine recommended by MTUS for treatment of chronic pain. Therefore, medical necessity is not established for Terocin lotion.