

Case Number:	CM14-0026255		
Date Assigned:	06/20/2014	Date of Injury:	08/13/2008
Decision Date:	07/21/2014	UR Denial Date:	02/03/2014
Priority:	Standard	Application Received:	03/03/2014

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. 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 37 year old female who reported an injury on 08/13/2008. The mechanism of injury reported by the injured worker was that she sustained the injury after attempting to lift a patient on a wheelchair. The injured worker complained of mid and low back pain that radiates to the right lower extremity. Physical examination noted tenderness to the mid and low back upon palpation. A magnetic resonance imaging (MRI) of the lumbar spine on 02/26/2010 noted degenerative disc disease at L4-S1 without significant spinal canal or foraminal stenosis. The injured worker's diagnosis includes low back pain with intermittent referred pain into the right lower extremity due to chronic muscle paraspinal strain and right thoracic paraspinal muscle strain. Previous treatments included medications, physical therapy, lumbar epidural steroid injection and chiropractic therapy. Medications include tramadol 150mg twice a day as needed, naproxen 550mg three times a day as needed, omeprazole 20mg once a day and Terocin lotion as needed. The requested treatment plan was to engage in activities as tolerated, use hot and cold modalities as needed and continue with current medications. The request for authorization form and rationale dated 01/19/2014 was included with the documentation submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Prontonix 20 mg, QTY: 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS (NON-STEROIDAL ANTI-INFLAMMATORY DRUGS).

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

Decision rationale: The request for Protonix 20mg is not medically necessary. The injured worker has a history and mid and low back pain and treating with medications. The California MTUS recommends that patient at intermediate risk for gastrointestinal events and no cardiovascular disease, a combination of a non-selective non-steroidal anti-inflammatory drug (NSAID) (e.g. Naproxen, ibuprofen, etc.) with either a proton pump inhibitor (PPI) or misoprostol or Cox-2 selective agent. Also long term proton pump inhibitor use (>1 year) has been shown to increase the risk of hip fracture. The injured worker's physical examination noted blood pressure and pulse within normal limits and no acute distress. The injured worker has no history of hypertension or diabetes and denies smoking, alcohol or illicit drug use. However, the medication requested did not have a frequency notated nor did it document the length of time the medication has been prescribed for and how long it would continue. Based on the above noted, the request is not medically necessary.

LidoPro lotion 4 ox, QTY: 1: 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): 111-112.

Decision rationale: The request for LidoPro lotion 4oz, quantity 1 is not medically necessary. The injured worker has a history of mid & low back pain that radiates to the right lower extremity. The California MTUS states that for topical analgesics consisting of any compounded product that contains at least one drug (or drug class) that is not recommended will not be recommended. The use of these compounded agents requires knowledge of the specific analgesic effect of each agent and how it will be useful for the specific therapeutic goal required. Lidopro is a compounded product that contains Capsaicin 0.0325%, Lidocaine 4.5%, Menthol 10% and Methyl Salicylate 27.5%. The California MTUS states for Lidocaine it is recommend for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or serotonin-norepinephrine reuptake inhibitor (SNRI) anti-depressants or an antiepileptic drug (AED) such as gabapentin or Lyrica). For Capsaicin it is recommended only as an option in patients who have not responded or are intolerant to other treatments. Documentation submitted did not provide evidence of a trial of first-line therapy and failure to improve symptoms. Documentation submitted did notate that previous treatments included medications, physical therapy, lumbar epidural steroid injection and chiropractic therapy however it did not notate the injured workers response to the previous treatments. There is a lack of documentation to indicate to which treatments the injured worker failed to respond to or was intolerant of. Additionally the requested medication did not notate the frequency and location to be applied to. Based on the above noted, the request is not medically necessary.

Tramadol ER 150 mg, QTY: 30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol (Ultram) Page(s): 113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use Page(s): 76-78.

Decision rationale: The request for Tramadol ER 150mg, QTY 30 is not medically necessary. The injured worker has a history of mid and low back pain that radiates to the right lower extremity. Previous treatments included medications, physical therapy, lumbar epidural steroid injection (ESI) and chiropractic therapy. The California MTUS on opioids requires ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non-adherent) drug-related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors). There is a lack of documentation to indicate the injured workers pain assessment had been completed. In addition documentation did not notate the effects of the medication had on the injured workers activities of daily living, if the injured worker had experienced any adverse side effects and if any routine urine drug screens had been performed or scheduled to monitor the injured worker's medication use. The medication request also did not specify the frequency to be taken. Based on the above noted, the request is not medically necessary.