

Case Number:	CM14-0036752		
Date Assigned:	06/25/2014	Date of Injury:	10/02/2003
Decision Date:	09/16/2014	UR Denial Date:	03/14/2014
Priority:	Standard	Application Received:	03/26/2014

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 has a subspecialty in: Pain Medicine 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 59-year-old female with a reported date of injury on 10/02/2003. Her diagnoses were noted to include L4/5 retrolisthesis, L5/S1 spondylosis, status post ALDF to L4-S1, and LRS to L4-S1. Her previous treatments were noted to include surgery, physical therapy, epidural steroid injection, and medications. The progress note dated 03/10/2014 revealed the injured worker reported she did not want to have surgery and she had been complaining of low back pain and cramping in her legs. The injured worker had lumbar spine surgery and there was no evidence of fusion. The injured worker complained of neck pain that radiated into the left shoulder. The physical examination revealed normal reflex, sensory and power testing to the bilateral upper and lower extremities except for weakness and numbness on the left at C7. The straight leg raise test was negative and there was minimal lumbar tenderness. The lumbar spine range of motion was decreased by about 20%. The cervical spine range of motion was decreased by 25% and there was a positive Spurling's. The injured worker indicated that the medications helped her. The Request for Authorization form was not submitted within the medical records. The request was for Prilosec 20 mg #60 (retro), Fexmid 7.5 mg #60 (retro), Ultram 150 mg #60 (retro), Methoderm ointment (retro), Norco 10/325 mg #90 (retro); however, the provider's rationale was not submitted within the medical records.

IMR ISSUES, DECISIONS AND RATIONALES

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

Prilosec 20 mg #60 (retro): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAID Page(s): 68.

Decision rationale: The request for Prilosec 20 mg #60 (retro) is not medically necessary. The injured worker has been utilizing this medication since at least 10/2013. The California Chronic Pain Medical Treatment Guidelines state physicians should determine if the patient is at risk for gastrointestinal events such as, age greater than 65 years, history of peptic ulcer, gastrointestinal bleeding or perforation, concurrent use of aspirin, corticosteroids and/or an anticoagulant, or high dose/multiple NSAIDs. There is a lack of documentation regarding efficacy of this medication. There was a lack of documentation regarding NSAID utilization to warrant Prilosec. There is a lack of documentation regarding stomach irritation to warrant Prilosec. Additionally, the request failed to provide a frequency at which this medication is to be utilized. Therefore, the request is not medically necessary.

Flexmid 7.5 mg #60 (retro): Upheld

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 Page(s): 63.

Decision rationale: The request for Fexmid 7.5 mg #60 (retro) is not medically necessary. The injured worker has been utilizing this medication since at least 10/2013. The California Chronic Pain Medical Treatment Guidelines recommend non-sedating muscle relaxants with caution as a second line option for short-term treatment of acute exacerbations in patients with chronic low back pain. Muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in most low back pain cases, they show no benefit beyond NSAIDs in pain and overall improvement. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. The injured worker has been utilizing this medication for over 6 months and the guidelines recommend short term utilization. There is a lack of documentation regarding muscle spasms to warrant Fexmid and the request failed to provide the frequency at which this medication is to be utilized. Therefore, the request is not medically necessary.

Ultram 150 mg #60 (retro): Upheld

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

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

Decision rationale: The request for Ultram 150 mg #60 (retro) is not medically necessary. The injured worker has been utilizing this medication since at least 10/2013. According to the California Chronic Pain Medical Treatment Guidelines, the ongoing use of opioid medications may be supported with detailed documentation of pain relief, functional status, appropriate medication use, and side effects. The guidelines also state that the 4 A's for ongoing monitoring including analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors, should be addressed. There is a lack of evidence of decreased pain on a numerical scale with the use of medications. There is a lack of documentation regarding improved functional status with activities of daily living with the use of medications. There is a lack of documentation regarding side effects. The urine drug screen performed 10/2013 was consistent with therapy. Therefore, due to the lack of documentation regarding evidence of decreased pain, improved functional status, and side effects, the ongoing use of opioid medications is not supported by the guidelines. Additionally, the request failed to provide the frequency at which this medication is to be utilized. Therefore, the request is not medically necessary.

Menthoderm Ointment (retro): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Compounding Medications Page(s): 71.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics; Salicylate topical Page(s): 111,105.

Decision rationale: The request for Menthoderm ointment (retro) is not medically necessary. The injured worker has been utilizing this medication since at least 10/2013. The California Chronic Pain Medical Treatment Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. The guidelines primarily recommend topical analgesics for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended, is not recommended. The guidelines recommend topical salicylates and state that it is significantly better than placebo in chronic pain. There is a lack of documentation regarding efficacy of this medication or the injured worker's inability to take oral medications. Additionally, the request failed to provide the frequency at which this medication is to be utilized. Therefore, the request is not medically necessary.

Norco 10/325 mg #90 (retro): Upheld

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

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

Decision rationale: The request for Norco 10/325 mg #90 (retro) is not medically necessary. The injured worker has been utilizing this medication since at least 10/2013. According to the California Chronic Pain Medical Treatment Guidelines, the ongoing use of opioid medications may be supported with detailed documentation of pain relief, functional status, appropriate medication use, and side effects. The guidelines also state that the 4 A's for ongoing monitoring including analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors, should be addressed. There is a lack of evidence of decreased pain on a numerical scale with the use of medications. There is a lack of documentation regarding and prefunctional status with activities of daily living with the use of medications. There is a lack of documentation regarding side effects. The urine drug screen performed 10/2013 was consistent with therapy. Therefore, due to the lack of documentation regarding evidence of decreased pain, improved functional status, and side effects, the ongoing use of opioid medications is not supported by the guidelines. Additionally, the request failed to provide the frequency at which this medication is to be utilized. Therefore, the request is not medically necessary.