

Case Number:	CM14-0037864		
Date Assigned:	07/18/2014	Date of Injury:	09/28/2011
Decision Date:	11/05/2014	UR Denial Date:	03/12/2014
Priority:	Standard	Application Received:	03/31/2014

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, 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 55-year-old male who reported an injury on 09/28/2011 due to an unknown mechanism. Diagnoses were disc protrusion of the cervical spine, disc protrusion of the lumbar spine, with right sided radiculopathy, head injury with memory loss and headaches. Physical examination dated 04/25/2014 revealed complaints of neck and low back pain, also memory loss and associated headaches. Examination of the cervical spine revealed spasm was present posteriorly. There was tenderness upon palpation posteriorly. There was pain with range of motion. Examination of the lumbar spine revealed spasm was present about the lumbar spine. Tenderness upon palpation was present about the lumbar spine. There was pain with range of motion. Neurological examination was normal. Treatment plan was referral to neurology for memory loss. Also, to take medications as directed. The Request for Authorization was not submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10-325, # 120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 91.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Norco, Ongoing Management Page(s): 75, 78.

Decision rationale: The decision for Norco 10/325, quantity 120, is not medically necessary. The California Medical Treatment Utilization Schedule Guidelines recommend short acting opioids such as Norco for controlling chronic pain. For ongoing management, there should be documentation of the 4 A's, including analgesia, activities of daily living, adverse side effects, and aberrant drug taking behavior. The 4 A's for ongoing management of an opioid medication were not reported. The efficacy of this medication was not reported. The request does not indicate a frequency for the medication. Therefore, this request is not medically necessary.

Protonix 20 mg, # 60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67.

Decision rationale: The decision for Protonix 20 mg, #60 is not medically necessary. Clinicians should determine if the patient is at risk for gastrointestinal (GI) events which include age > 65 years, a history of peptic ulcer, GI bleeding or perforation, concurrent use of ASA, corticosteroids, and/or an anticoagulant; or using high dose/multiple non-steroidal anti-inflammatory drugs (NSAIDs). Patients with no risk factor and no cardiovascular disease: Non-selective NSAIDs OK (e.g., ibuprofen, naproxen, etc.) Patients at intermediate risk for gastrointestinal events and no cardiovascular disease: (1) A non-selective NSAID with either a PPI (Proton Pump Inhibitor, for example, 20 mg omeprazole daily) or misoprostol (200 g four times daily) or (2) a Cox-2 selective agent. Long-term PPI use (> 1 year) has been shown to increase the risk of hip fracture (adjusted odds ratio 1.44). Patients at high risk for gastrointestinal events with no cardiovascular disease: A Cox-2 selective agent plus a PPI if absolutely necessary. The efficacy of this medication was not reported. The request does not indicate a frequency for the medication. There was no diagnosis of any type of GI events to support the continued use. Therefore, this request is not medically necessary.

Soma 350 mg, # 120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 91.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol Page(s): page 29, 65.

Decision rationale: The decision for soma 350 mg, quantity 120, is not medically necessary. The California Medical Treatment Utilization Schedule states that soma (carisoprodol) is not indicated for longer than a 2 to 3 week period. Carisoprodol is a commonly prescribed, centrally acting skeletal muscle relaxant. It has been suggested that the main effect is due to generalized

sedation and treatment of anxiety. Abuse has been noted for sedative and relaxant effects. Carisoprodol abuse has also been noted in order to augment or alter effects of other drugs. A withdrawal syndrome had been documented that consists of insomnia, vomiting, tremors, muscle twitching, anxiety, and ataxia when abrupt discontinuation of large doses occurs. Tapering should be individualized for each patient. The efficacy of this medication was not reported. The request does not indicate a frequency for the medication. The medical guidelines state that this medication should be used for no longer than a 2 to 3 week period. The clinical documentation submitted for review does provide evidence that the injured worker has been on this medication for an extended duration of time. Therefore, this request is not medically necessary.

VALIUM 10 MG, # 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 24.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

Decision rationale: The decision for Valium 10 mg, quantity 60, is not medically necessary. The California Medical Treatment Utilization Schedule Guidelines do not recommend the use of benzodiazepines as treatment for patients with chronic pain for longer than 3 weeks due to a high risk of psychological and physiological dependency. The clinical documentation submitted for review does provide evidence that the patient has been on this medication for an extended duration of time. The request does not indicate a frequency for the medication. Therefore, continued use would not be supported. Therefore, this request is not medically necessary.