

Case Number:	CM14-0038514		
Date Assigned:	07/30/2014	Date of Injury:	02/15/2007
Decision Date:	09/11/2014	UR Denial Date:	03/20/2014
Priority:	Standard	Application Received:	04/01/2014

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 Nevada. 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 records presented for review, indicate this 52-year-old female was reportedly injured on February 15, 2007. The mechanism of injury was noted as moving a patient in bed. The most recent progress note, dated May 14, 2014, indicated there were ongoing complaints of low back pain. It was noted the pain level was about the same subsequent to the prior evaluation. The physical examination demonstrated a 5'2, 228 pound individual who is normotensive. There was tenderness to palpation in the cervical and lumbar spine. A decrease in range of motion was reported in the cervical lumbar spine. Motor function was 5/5 in all extremities. No specific sensory losses identified. Straight leg raising was positive on the left and 60. Diagnostic imaging studies objectified findings diffuse spondylosis, disc protrusion at T9-T10 and T8-T9. Previous treatment included multiple medications, physical therapy, pain intervention techniques. A request was made for multiple medications and was not certified in the pre-authorization process on March 20, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective usage of Hydrocodone/APAP 5/325mg (DOS 7/13/13, 8/14/12, 9/16/13, 10/15/13, 11/14/13, 12/20/13): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines : 8 C.C.R. 9792.20 - 9792.26 (Effective July 18, 2009) Page(s): 74-78.

Decision rationale: As outlined in the MTUS, this is a short acting opioid analgesic designed to address the short-term management of moderate to severe breakthrough pain. The last several progress notes reviewed indicate ongoing complaints of pain described as throbbing, aching and burning. There was no noted decrease in the symptoms, increase in functionality, a return to work ability or any other parameters by which it would be indicated that there is any efficacy associated with this medication. Therefore, based on the clinical information presented for review, there is no medical necessity for this medication.

Retrospective usage of Gabapentin 300mg (DOS 7/13/13, 8/14/13, 9/16/13, 10/15/13, 11/14/13, 12/20/13, 01/24/14, 03/05/14): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines : 8 C.C.R. 9792.20 - 9792.26 (Effective July 18, 2009) Page(s): 16-20, 49.

Decision rationale: The progress notes indicate that electrodiagnostic testing has been completed. However, there was no objectification of a verifiable radiculopathy. Furthermore, there was no indication that this medication has had any effect in terms of mitigating symptomatology. In the MTUS outlines, this is designed to treat painful diabetic neuropathy or post-herpetic neuralgia, and that there is off label use for neuropathic lesions. There was no indication that such a lesion existed. Furthermore, the progress over the last six months did not offer any indication of amelioration of symptomatology. Therefore, this is not clinically indicated.

Retrospective usage of Cyclobenzaprine 10mg (DOS 7/13/13, 8/14/13, 09/16/13, 10/15/13, 11/14/13, 12/20/13, 01/24/14, 03/05/14): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants. Decision based on Non-MTUS Citation Official Disability Guidelines Chronic Pain Muscle Relaxants.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines : 8 C.C.R. 9792.20 - 9792.26 (Effective July 18, 2009): Muscle relaxants Page(s): 41, 64.

Decision rationale: This is a muscle relaxant type medication and as outlined in the MTUS Guidelines, it is indicated for short-term use of muscle spasm for acute flares. There was no clinical indication for the chronic, indefinite routine use of this medication. Furthermore, the progress notes over the last several months do not indicate that there has been any relief of symptomatology or efficacy with the medication used. Therefore, there is no medical necessity for this preparation.

Retrospective usage of Ibuprofen 800mg (DOS 8/14/12, 09/16/13, 11/14/13): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines : 8 C.C.R. 9792.20 - 9792.26 (Effective July 18, 2009) Page(s): 22.

Decision rationale: This is a nonselective, non-steroidal anti-inflammatory medication, which has some indication for chronic low back pain. Clearly, there was a diagnosis of low back pain. However, there is no indication of any improvement in the symptoms or increase in functionality. As such, the utility of such a medication has not been established. Therefore, the medical necessity is not present.

Retrospective usage of Nexium 20mg (DOS 8/14/13, 9/17/13): Upheld

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

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

Decision rationale: This is a proton pump inhibitor use for the treatment of Gastroesophageal reflux disease. It is also used as a protectorate when non-steroidal anti-inflammatory medications are being employed. However, a Cox-2 medication was used and there were no complaints of gastrointestinal distress. Therefore, based on the limited clinical information presented for review, there is no indication for the need for this medication. This is not medically necessary.

Retrospective usage of Omeprazole 20mg (DOS 10/16/13, 11/18/13, 12/23/13, 01/24/14, 03/05/14): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines : 8 C.C.R. 9792.20 - 9792.26 (Effective July 18, 2009) Page(s): 68.

Decision rationale: This is a proton pump inhibitor used for the treatment of Gastroesophageal reflux disease. It is also used as a protectorate when non-steroidal anti-inflammatory medications are being employed. However, a Cox-2 medication was used and there were no complaints of gastrointestinal distress. Therefore, based on the limited clinical information presented for review, there is no indication for the need for this medication. This is not medically necessary.

Retrospective Oxycodone/APAP 7.5/325mg (DOS 1/24/14, 03/05/14): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines : C.C.R. 9792.20 - 9792.26 (Effective July 18, 2009) Page(s): 74, 78, 93.

Decision rationale: As outlined in the MTUS, this is the opioid for the short-term management of moderate to severe breakthrough pain. Management of opiate medications should include the lowest possible dose. Furthermore, there needs to be establishment that the medications being used accomplished pain relief, improved functional status and have no inappropriate side effects. These criteria were addressed in the progress notes presented for review. As such, the clinical indication or medical necessity for this medication has not been established.

Hydrocodone/APAP 5/325mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines : 8 C.C.R. 9792.20 - 9792.26 (Effective July 18, 2009) Page(s): 74-78.

Decision rationale: When considering the date of injury, the injury sustained, the response to the medication of the last several months and taking into consideration the parameters outlined in the MTUS (that this is for the short-term relief or management of life), there is no efficacy presented with the use of this medication. There has been no decrease in the pain complaints. There was no increase functionality, and there was no return to work. As such, based on the limited clinical fracture presented for review, there was no narrative presented to support the continued use of this medication. The medical necessity is not derived from this record.

Gabapentin 300mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines : 8 C.C.R. 9792.20 - 9792.26 (Effective July 18, 2009) Page(s): 16-20, 49.

Decision rationale: As outlined in the MTUS, use of this medication is to address painful diabetic neuropathy or post-herpetic neuralgia. There is an off label use for addressing neuropathic lesions and there is no data presented to suggest that there is a specific neuropathic lesion. There were vague complaints of neck pain, low back pain and there was no noted efficacy or utility in terms of the medications. As such, this is not clinically indicated.

Cyclobenzaprine 10mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants. Decision based on Non-MTUS Citation Official Disability Guidelines Pain Procedure Summary, muscle relaxants.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines : 8 C.C.R. 9792.20 - 9792.26 (Effective July 18, 2009) Page(s): 41, 64.

Decision rationale: This is a muscle relaxant type medication and as outlined in the MTUS indicated for short-term use of muscle spasm for acute flares. There was no clinical indication for the chronic, indefinite routine use of this medication. Furthermore, the progress notes over the last several months do not indicate that there has been any relief of symptomatology or efficacy with the medication used. Therefore, there is no medical necessity for this preparation.

Ibuprofen 800mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines : 8 C.C.R. 9792.20 - 9792.26 (Effective July 18, 2009) Page(s): 22.

Decision rationale: This is a nonselective, non-steroidal anti-inflammatory medication, which has some indication for chronic low back pain. Clearly, there is a diagnosis of low back pain. However, there was no indication of any improvement in the symptoms or increased functionality. As such, the utility of such a medication has not been established. Therefore, the medical necessity is not present.

Nexium 20mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines : 8 C.C.R. 9792.20 - 9792.26 (Effective July 18, 2009) Page(s): 68.

Decision rationale: This is a proton pump inhibitor use for the treatment of Gastroesophageal reflux disease. It is also used as a protectorate when non-steroidal anti-inflammatory medications are being employed. However, a Cox-2 medication was used and there were no complaints of gastrointestinal distress. Therefore, based on the limited clinical information presented for review, there is no indication for the need for this medication. This is not medically necessary.

Omeprazole 20mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines : 8 C.C.R. 9792.20 - 9792.26 (Effective July 18, 2009) Page(s): 68.

Decision rationale: This is a proton pump inhibitor used for the treatment of Gastroesophageal reflux disease. It is also used as a protectorate when non-steroidal anti-inflammatory medications are being employed. However, a Cox-2 medication was used, and there were no complaints of gastrointestinal distress. Therefore, based on the limited clinical information presented for review, there is no indication for the need for this medication. This is not medically necessary.

Oxycodone/APAP 7.5/325mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines : C.C.R. 9792.20 - 9792.26 (Effective July 18, 2009) Page(s): 74, 78, 93.

Decision rationale: As outlined in the MTUS, this is an opioid for the short-term management of moderate to severe breakthrough pain. Management of opiate medications should include the lowest possible dose. Furthermore, there needs to be establishment that the medications being used accomplished pain relief, improved functional status and have no inappropriate side effects. These criteria were not addressed in the progress notes of the review. As such, the clinical indication or medical necessity for this medication has not been established.