

| | | | |
|-----------------------|--------------|------------------------------|------------|
| Case Number: | CM14-0046035 | | |
| Date Assigned: | 07/02/2014 | Date of Injury: | 03/08/2011 |
| Decision Date: | 10/13/2014 | UR Denial Date: | 03/21/2014 |
| Priority: | Standard | Application Received: | 04/14/2014 |

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 injured worker is a 54 year-old male who was reportedly injured on March 8, 2011. The injured employee is noted to be at a permanent and stationary status. The most recent progress note dated February 11, 2014, indicates that there are ongoing complaints of neck and lower back pain. The physical examination demonstrated a 5'11", 301 pound individual. A weakness into the bilateral upper and lower extremities is reported. A reduced range of motion is identified as was an antalgic gait pattern. Diagnostic imaging studies objectified degenerative changes in the cervical and lumbar spine with no evidence of instability. Previous treatment includes multiple medications, physical therapy, and pain management interventions. A request had been made for multiple medications and was not certified in the pre-authorization process on March 21, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325mg #120 with 1 refill: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-78, 88, 91.

Decision rationale: Norco (hydrocodone/acetaminophen) is a short acting opiate indicated for the management in controlling moderate to severe pain. This medication is often used for intermittent or breakthrough pain. The California Medical Treatment Utilization Schedule guidelines support short-acting opiates at the lowest possible dose to improve pain levels and increased overall functionality. The ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects. There is no objective clinical documentation of improvement in their pain or function with the current regimen. As such, this request for Norco is not considered medically necessary.

Prilosec 20mg #60 with 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines anti-inflammatory medications and gastrointestinal symptoms.

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

Decision rationale: This medication is a protein pump inhibitor useful for the treatment of gastroesophageal reflux disease. This medication can also uses a protectorate for those individuals taking oral non-steroidal anti-inflammatory medications. However, there were no complaints of gastrointestinal distress noted in the progress notes reviewed and there are no findings of fiddle examination to support any compromise to the gastrointestinal track. Therefore, based on the clinical information presented in the progress of reviewed tempered by the parameters outlined in the California Medical Treatment Utilization Schedule there is insufficient clinical information support the medical necessity for continuing use of medication.

Fexmid 7.5mg #90 with 1 refill: 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): 41, 64.

Decision rationale: California Medical Treatment Utilization Schedule Guidelines support the use of skeletal muscle relaxants for the short-term treatment of pain, but advises against long-term use. Given the claimant's date of injury and clinical presentation, the guidelines do not support this request for chronic pain. As such, the request is not medically necessary.

Ambien 10mg #30 with 1 refill: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter

Decision rationale: As noted in the ODG (MTUS and ACOEM guidelines do not address) this is a short-term, short acting non-benzodiazepine hypnotic. This is indicated for short-term treatment of insomnia (up to 6 weeks) and not for chronic or indefinite use. Furthermore, with the understanding that sleep hygiene is crucial in treating chronic pain, there is no documentation of a how much sleep was being accomplished with this medication. Therefore, there is insufficient clinical information presented the medical necessity for the ongoing uses preparation.

Anaprox 550mg #60 with 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CA MTUS Chronic Pain Medical Treatment Guidelines section on anti-

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 66, 73.

Decision rationale: This medication is supported in the California Medical Treatment Utilization Schedule as an option to address the signs and symptoms of osteoarthritis. When noting there were multiple changes in the cervical lumbar spine there would be an indication, however, there is no demonstrated efficacy as there is no increased functionality or decrease in pain control. Therefore, this is not medically necessary.