

Case Number:	CM14-0048466		
Date Assigned:	08/08/2014	Date of Injury:	05/19/1997
Decision Date:	09/17/2014	UR Denial Date:	04/07/2014
Priority:	Standard	Application Received:	04/16/2014

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 and is licensed to practice in Illinois. 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 05/19/1997. The injured worker was using an overhead hoist, when he lost his balance, which caused a twisting motion of his body. The injured worker reportedly sustained an injury to his low back that ultimately resulted in anterior lumbar interbody fusion at the L4-5. The injured worker was evaluated on 01/21/2014. It was documented that the injured worker had persistent pain complaints of the neck, upper back, and low back rated at an 8/10 to 0/10. The injured worker's medications included Lonox 2.5/0.025 mg, ammonium lactate lotion 5%, Lidoderm patches, Lorazepam 1 mg, Prilosec 20 mg, and Flexeril. Physical findings at that appointment included bilateral upper and lower extremity motor strength rated at a 5-/5. It was noted that the injured worker's most recent urine toxicology report dated 09/30/2013 was positive for oxycodone. It was noted that the injured worker's CURES report was consistent on 10/23/2013. It was also noted that the injured worker reported being bed bound without medication usage. The injured worker's diagnoses included status post anterior and lumbar interbody fusion at the L4-5, possible lumbar radiculopathy, chronic pain syndrome, and failed low back surgery syndrome. A request was made for a refill of medications. A request for authorization form was submitted on 01/21/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cyclobenzaprine 7.5mg tablet #30, dispensed 01/21/14: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63.

Decision rationale: The requested cyclobenzaprine 7.5 mg tablets #30 is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends short durations of treatment, not to exceed 2 to 3 weeks for acute exacerbation of chronic pain. The clinical documentation submitted for review does indicate that the injured worker has been on cyclobenzaprine for an extended duration. Therefore, continued use would not be indicated in this clinical situation. Furthermore, clinical documentation does not provide an adequate assessment of pain relief to support continued use. It is noted that the injured worker is bed bound without medications; however, a reduction in the injured worker's 8/10 pain is not provided to support continued medication usage. Furthermore, the request as it is submitted, does not clearly identify a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested cyclobenzaprine 7.5 mg tablets #30, dispensed 01/21/2014, is not medically necessary or appropriate.

Ketoprofen 75mg capsule #90, dispensed 01/21/14: 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 Chronic pain and NSAIDs Page(s): 60, 68.

Decision rationale: The requested ketoprofen 75 mg capsules #90 dispensed 01/21/2014 is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does recommend nonsteroidal anti-inflammatory drugs as a first line medication in the management of chest pain. The California Medical Treatment Utilization Schedule recommends that all medications used in the management of chronic pain be supported by documented functional benefit and evidence of pain relief. The clinical documentation does not provide an adequate assessment of pain relief to support continued use. It is noted that the injured worker has 8/10 to 9/10 pain and is essentially bed bound without medications. However, there is no documentation of a quantitative assessment of a reduction in pain resulting from the use of this medication. Therefore, continued use would not be supported in this clinical situation. Furthermore, the request as it is submitted does not clearly identify frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested ketoprofen 75 mg capsules #90 dispensed 01/20/2014, is not medically necessary or appropriate.

Omeprazole 20mg capsule #60, dispensed 01/21/14: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk.

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

Decision rationale: The requested omeprazole 20 mg capsule #60 dispensed 01/21/2014 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends the ongoing use of gastrointestinal protectants be supported by documentation of risk factors contributing to gastrointestinal disturbances related to medication usage. The clinical documentation submitted for review does indicate that the injured worker has been taking this medication for an extended duration of time. However, an adequate assessment of the injured worker's risk factors of gastrointestinal disturbances related to medication usage is not provided. Furthermore, the request as it is submitted does not clearly identify a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested omeprazole 20 capsules #60 dispensed 01/21/2014 is not medically necessary or appropriate.

Lonox 2.5/0.025 #90: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.drugs.com/mtm/lonox.html> - Lonox - Generic name: atropine and diphenoxylate.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic pain Page(s): 60.

Decision rationale: The requested Lonox 2.5/0.025 #90 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends that all medications used in the management of chronic pain be supported by documented functional benefit and evidence of symptom relief. The clinical documentation submitted for review does indicate that the injured worker would be essentially bed bound without medication usage; however, the clinical documentation indicates the injured worker's pain level was reported to be 8/10. There is no evidence of a reduction in pain resulting from the use of this medication. Therefore, ongoing use would not be supported. Furthermore, the request as it is submitted does not clearly identify a frequency of treatment. In the absence of this information, the request as it is submitted does not clearly identify a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Lonox 2.5/0.025 #90 is not medically necessary or appropriate.

Ammonium Lactate #1: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.drugs.com/pro/ammonium-lactate.html> - Indications and Usage for Ammonium Lactate.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic pain Page(s): 60.

Decision rationale: The requested ammonium lactate #1 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends that all medications used in the management of chronic pain be supported by documented functional benefit and evidence of symptom relief. The clinical documentation submitted for review does indicate that the injured worker would be essentially bed bound without medication usage; however, the clinical documentation indicates the injured worker's pain level was reported to be 8/10. There is no evidence of a reduction in pain resulting from the use of this medication. Therefore, ongoing use would not be supported. Furthermore, the request as it is submitted does not clearly identify a frequency of treatment. In the absence of this information, the request as it is submitted does not clearly identify a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested ammonium lactate is not medically necessary or appropriate.

Lidoderm patches #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, Lidocaine Indication.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

Decision rationale: The requested Lidoderm patches #30 are not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends the use of Lidoderm patches when the injured worker has failed to respond to oral anticonvulsants. Additionally, continued use should be supported by documented functional benefit and evidence of pain relief. The clinical documentation submitted for review does not clearly identify that the injured worker has failed to respond to oral anticonvulsant medications. Furthermore, the clinical documentation does not provide any evidence of pain relief resulting from the use of this medication. Also, the request as it is submitted does not clearly identify a frequency of treatment or dosage. In the absence of this information, the request as it is submitted does not clearly identify a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Lidoderm patches #30 are not medically necessary or appropriate.

Percocet 10/325mg #150: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of Opioids.

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

Decision rationale: The requested Percocet 10/325 mg #150 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends the ongoing use of opioids in the management of chronic pain be supported by documented functional benefit, evidence of pain relief, managed side effects, and evidence that the injured worker is monitored for aberrant behavior. The clinical documentation submitted for review does indicate that the injured worker is monitored for aberrant behavior with urine drug screens and CURES reporting. Additionally, it is noted that the injured worker is bed bound without medications. However, the clinical documentation indicates that the injured worker has 8/10 pain. A quantitative assessment of a reduction in pain resulting from medication usage was not provided. Therefore, the efficacy of this medication is not indicated. Also, the request as it is submitted does not clearly identify a frequency of treatment. In the absence of this information, the request as it is submitted does not clearly identify a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Percocet 325 mg #150 is not medically necessary or appropriate.