

Case Number:	CM14-0079126		
Date Assigned:	07/18/2014	Date of Injury:	02/08/2012
Decision Date:	08/29/2014	UR Denial Date:	05/12/2014
Priority:	Standard	Application Received:	05/29/2014

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 Occupational Medicine and is licensed to practice in California. 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:

This patient is a 44 year old female employee with date of injury of 2/8/2012. A review of the medical records indicate that the patient is undergoing treatment for lumbar radiculitis, lumbar spine sprain/strain and right-sided sacroiliac joint sprain. Subjective complaints (5/14/2014) included pain to right hip, no real improvement since last visit, and anterior groin pain that is worse with walking. Progress note dated 5/5/2014 noted epigastric pain and nausea. Objective findings (5/5/2014) included an antalgic gait, TTP over the left and right lumbar paraspinal muscles, limited active range of motion with left lateral bending and right lateral bending, and 4/5 iliopsoas muscular strength. Treatment has included medication and right hip arthroscopy, physical therapy, and home therapy program. Medications have included Dialudid, Gabapentin 300mg, Lidoderm, Motrin 800mg, and Flexeril 5mg. The utilization review dated 5/12/2014 is not medically necessary the following: Protonix 40 mg #30 with one (1) refill due to lack of documented first line failure, Lidoderm 5% adhesive patch #30 with one (1) refill due to lack of documented first line failure, Dilaudid 2 mg #60 with one (1) refill due to lack of single prescribing provider and Soma 350 mg #60 with one (1) refill due to lack of documented spasms.

IMR ISSUES, DECISIONS AND RATIONALES

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

Protonix 40 mg #30 with one (1) refill: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68-69. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), NSAIDs, GI symptoms & cardiovascular risk.

Decision rationale: The medical documents provided establish the patient has GI complaints treatment may be appropriate. However, the treating physician has provided no documentation of a failed trial of omeprazole or lansoprazole prior to starting Protonix therapy. The request for Protonix 40 mg #30 with one (1) refill is not medically necessary.

Lidoderm 5% adhesive patch #30 with one (1) refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation ODG.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm patches Page(s): 56-57. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: UpToDate.com, Lidocaine (topical).

Decision rationale: Medical documents provided do not indicate that the use would be for post-herpetic neuralgia. Treatment notes did indicate ongoing treatment with Gabapentin, but does not document that this first-line therapy has 'failed'. The request for Lidoderm 5% patches is not medically necessary.

Dilaudid 2 mg #60 with one (1) refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation ODG.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 51, 74-96. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), Opioids.

Decision rationale: Per MTUS, Dilaudid is the brand name version of Hydromorphone, which is a pure agonist/short acting opioid and they are often used for intermittent or breakthrough pain. (ODG) does not recommend the use of opioids for low back pain except for short use for severe cases, not to exceed 2 weeks. The patient has been on Dilaudid since at least 11/2013, exceeding the 2 week recommended treatment length for opioid usage. MTUS does not discourage use of opioids past 2 weeks, but does state that ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased

level of function, or improved quality of life. The treating physician does not fully document this information per MTUS guidelines, which is necessary. The request for Dilaudid 2mg #60 with 1 refill is not medically necessary.

Soma 350 mg #60 with one (1) refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation ODG.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol (Soma) and Muscle relaxants (for pain) Page(s): 29, 63-66. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain, Soma (Carisoprodol).

Decision rationale: Medical documents indicate that the patient has been on Soma since at least 1/2014, far exceeding the recommended time limit. The request for #60 with refill also does not indicate that the treating physician intends on weaning the patient, per MTUS guidelines. The request for Soma 350MG, #60 with 1 refill is not medically necessary.