

Case Number:	CM14-0079976		
Date Assigned:	09/24/2014	Date of Injury:	10/09/1995
Decision Date:	10/29/2014	UR Denial Date:	04/29/2014
Priority:	Standard	Application Received:	05/30/2014

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 Texas and Ohio. 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 75-year-old male who reported an injury on 10/09/1995. The mechanism of injury was not provided. Diagnoses included lumbar spondylolisthesis, lumbar spinal stenosis, low back pain, lumbar radiculopathy, and severe bilateral carpal tunnel syndrome. Past treatments included medications. Pertinent diagnostic studies were not provided. Surgical history included a spinal fusion at T11 through S1. The clinical note dated 05/14/2014 indicated the injured worker complained of persistent low back pain rated 5/10. The physical examination revealed limited range of motion of the lumbar spine. Current medications included Cosamin DS 500/400 mg, ibuprofen 800 mg, hydrocodone 10/325 mg, and Celebrex 200 mg. The treatment plan included hydrocodone/APAP 10/325 mg #90, ibuprofen 800 mg #60, and Cosamin DS 500/400/16 mg #90 with 2 refills. The rationale for the treatment plan was pain control. The Request for Authorization form was not provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hydrocodone/APAP 10/325mg, #90: Upheld

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

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

Decision rationale: The request for Hydrocodone/APAP 10/325mg, #90 is not medically necessary. The California MTUS Guidelines indicate that four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids, including pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or nonadherent) drug related behaviors. The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. The injured worker complained of low back pain rated 5/10, made worse by range of motion of the lower back and walking long distances. He stated that the pain was alleviated by Cosamin and Norco. The injured worker had been taking the requested medication since at least 11/20/2013. There is a lack of clinical documentation of the efficacy of the requested medication, including quantified pain relief and functional improvement. Additionally, there is a lack of documentation of any potentially nonadherent drug related behaviors through the use of urine drug screens. The request also does not indicate the frequency for taking the medication. Therefore, the request for Hydrocodone/APAP 10/325mg, #90 is not medically necessary.

Ibuprofen 800mg, #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs), Page(s): pages 67-68..

Decision rationale: The request for Ibuprofen 800mg, #60 is not medically necessary. The California MTUS Guidelines indicate that nonsteroidal anti-inflammatory drugs are recommended as an option for the short term symptomatic relief of chronic low back pain. The injured worker complained of persistent low back pain, made worse by range of motion of the low back and walking long distances. He had been taking the requested medication since at least 11/20/2013, and had exceeded the guideline recommended short term use of the medication. Additionally, there is a lack of documentation of efficacy of the requested medication, including quantified pain relief and functional improvement. The request also does not indicate the frequency for taking the medication. Therefore, the request for Ibuprofen 800mg, #60 is not medically necessary.

Cosamin DS 500/400/16mg, #90 with 2 refills,: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Glucosamine (and Chondroitin Sulfate), Page(s): page 50..

Decision rationale: The request for Cosamin DS 500/400/16mg, #90 with 2 refills is not medically necessary. The California MTUS Guidelines indicate that glucosamine and

chondroitin sulfate are recommended as an option, given their low risk, in patients with moderate arthritis pain. The injured worker complained of persistent low back pain, rated 5/10, made worse by range of motion of the low back and walking long distances. He had been taking the requested medication since at least 11/20/2013. There is a lack of clinical documentation of the efficacy of the medication, including quantified pain relief and functional improvement. Additionally, there is a lack of clinical documentation of subjective complaints or physical examination findings indicating low back arthritis. The request also does not indicate the frequency for taking the medication. Therefore, the request for Cosamin DS 500/400/16mg, #90 with 2 refills is not medically necessary.