

Case Number:	CM14-0080230		
Date Assigned:	07/18/2014	Date of Injury:	10/22/1991
Decision Date:	09/17/2014	UR Denial Date:	05/23/2014
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 Pain Medicine and is licensed to practice in California and Washington. 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 63-year-old female who reported an injury on 10/22/1991 due to an unknown mechanism. Diagnoses were insomnia due to medical condition classifiable elsewhere, degeneration of lumbar or lumbosacral intervertebral disc, and spondylosis with myelopathy lumbar region. Past treatments have been acupuncture, physical therapy, biofeedback and 2 epidural steroid injections. Diagnostic studies were stress echocardiogram, MRI of the lumbar spine, discogram at the L5-S1, and CT of the spine. The injured worker had a physical examination on 06/11/2014 that revealed complaints of back pain. Typical pain was rated at a 7/10, with the worst days being an 8/10. It was reported she did have improvement in her activities of daily living with the medication. Physical examination revealed no fever or chills. No weight loss. Pulmonary: no cough, wheezing, hemoptysis. Cardiology: no chest pain or palpitation. No edema or orthopnea. GI: no nausea, emesis, diarrhea. Good appetite. Medications were cyclobenzaprine 10 mg, Hyzaar 100 mg, Motrin 800 mg, MS-Contin 60 mg, 1 every 12 hours up to 3 times a day, omeprazole 40 mg, oxycodone 5mg 1 twice a day as needed, pravastatin 20 mg, Rozerem tablets 8 mg, Vitamin B12, 250 mcg, Vitamin D3, 400 units. Treatment plan and Request for Authorization were not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Oxycodone 5mg, DOS 3/28/2014: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines. Decision based on Non-MTUS Citation 1. ODG-TWC Pain Procedure Summary, 2. Mosby's Drug Consult.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain, Oxycodone, Ongoing Management Page(s): 75, 86, 78.

Decision rationale: The request for oxycodone 5 mg, date of service 03/28/2014 is not medically necessary. The California Medical Treatment Utilization Schedule Guidelines recommend oxycodone for moderate to severe chronic pain and that there should be documentation of the 4 A's for ongoing monitoring including analgesia, activities of daily living, adverse side effects and aberrant drug taking behavior. It further recommends that dosing of opioids not exceed 120 mg oral morphine equivalence per day, and for patients taking more than 1 opioid, the morphine equivalent doses of the different opioids must be added together to determine the cumulative dose. Although the injured worker has reported pain relief and functional improvement from the medication the provided did not indicate a frequency for the medication. Therefore, the request is not medically necessary.

Avinzia Capsule 90mg, DOS 3/28/2014: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines. Decision based on Non-MTUS Citation 1. ODG-TWC Pain Procedure Summary, 2. Mosby's Drug Consult.

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

Decision rationale: The request for Avinza capsule 90 mg, date of service 03/28/2014 is not medically necessary. The California Medical Treatment Utilization Schedule Guidelines recommends that there should be documentation of the 4 A's for ongoing monitoring including analgesia, activities of daily living, adverse side effects and aberrant drug taking behavior. It further recommends that dosing of opioids not exceed 120 mg oral morphine equivalence per day, and for patients taking more than 1 opioid, the morphine equivalent doses of the different opioids must be added together to determine the cumulative dose. The frequency and the quantity for this medication were not reported to be able to calculate the morphine equivalent dose per day for the injured worker. This medication was not mentioned at the last physical exam submitted. With the oxycodone and the Avinza it is unknown the morphine equivalence per day. Also, the frequency and quantity were not indicated on the request. Therefore, the request is not medically necessary.

Nexium 40mg, DOS 3/28/2014: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines. Decision based on Non-MTUS Citation 1. ODG-TWC Pain Procedure Summary, 2. Mosby's Drug Consult.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 68, 69.

Decision rationale: The request for Nexium 40 mg, date of service 03/28/2014 is non-certified. The California Medical Treatment Utilization Schedule Guidelines states that clinicians should determine if the patient is at risk for gastrointestinal events which include age greater than 65 years, a history of peptic ulcer, gastrointestinal bleeding or perforation, concurrent use of aspirin, corticosteroids, and/or an anticoagulant, or using a high dose/multiple NSAID. Patients at intermediate risk for gastrointestinal events and new cardiovascular disease a non-selected NSAID with either a proton pump inhibitor or misoprostol, or a COX 2 selective agent. Long term proton pump inhibitor use greater than 1 year has been shown to increase the risk of hip fracture. There was no diagnosis to support the use of a proton pump inhibitor. It was not reported that the injured worker was taking an NSAID. There were no reports of gastrointestinal events. Also, the request does not indicate a frequency for the medication. Therefore, the request is not medically necessary.

Cyclobenzaprine 10mg, DOS 3/28/2014: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines. Decision based on Non-MTUS Citation 1. ODG-TWC Pain Procedure Summary, 2. Mosby's Drug Consult.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine Page(s): 41, 64.

Decision rationale: The request for cyclobenzaprine 10 mg, date of service 03/28/2014 is not medically necessary. The California Medical Treatment Utilization Schedule states that cyclobenzaprine (Flexeril) is recommended for a short course of therapy. Flexeril is more effective than placebo in the management of back; however, the effect is modest and comes at the price of greater adverse effects. The effect is greatest during the first 4 days of treatment, suggesting that shorter courses may be better. This medication is not recommended to be used for longer than 2 to 3 weeks. The efficacy of this medication was not reported. The request does not indicate a frequency or quantity for the medication. Therefore, the request is not medically necessary.

Rozerem Tablet 8mg, DOS 3/28/2014: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines. Decision based on Non-MTUS Citation 1. ODG-TWC Pain Procedure Summary, 2. Mosby's Drug Consult.

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

Decision rationale: The request for Rozerem tablet 8 mg, date of service 03/28/2014 is not medically necessary. The Official Disability Guidelines recommend melatonin. There is also

experimental and clinical data supporting an analgesic role of melatonin. In published studies melatonin shows potent analgesic effects in a dose dependent manner, and melatonin has been showed to have analgesic benefits in patients with chronic pain. Also, the repeated administration of melatonin improves sleep and thereby may reduce anxiety, which leads to lower levels of pain. The efficacy of this medication was not reported. Also, the request does not indicate a frequency of a quantity for the medication. Therefore, the request is not medically necessary.