MAXIMUS Federal Services

Case Number:	CM14-0080875		
Date Assigned:	07/21/2014	Date of Injury:	11/12/2009
Decision Date:	09/18/2014	UR Denial Date:	05/09/2014
Priority:	Standard	Application Received:	06/02/2014

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 Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in Tennessee. 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 is a 54-year-old male patient with an 11/12/2009 date of injury. The mechanism of injury was not described. The patient had also been in a non-industrial car accident on 3/17/2011 causing injury. On a progress report dated 4/21/14 the patient stated he has had no significant improvement since the last exam. He continues to have significant neck and back pain. On physical findings the paravertebral muscles are tender to palpation. Spasm is present and the range of motion (ROM) is restricted. An impingement test for the bilateral shoulders is positive; the ROM is stricted in flexion/abduction plane. The diagnostic impression is cervical spine strain, bilateral shoulder impingement syndrome, lumbar radiculopathy, right knee internal derangement, hypertension uncontrolled due to orthopedic condition, right sacroiliac joint radiculopathy per EMG/NCV studies, depressive disorder, and gastro-esophageal reflux disease.Treatment to date: Back brace, TENS unit, MRI, psychiatric evaluation, physical therapy, epidural steroid injections, chiropractic treatment, acupuncture, and medication management.A UR date of 5/9/14 denied the requests for omeprazole DR 20mg, Orphenadrine ER 100mg, Medrox Pain Relief Ointment, and hydrocodone/APAP 5/325. The rationale for denial of the request for Omeprazole DR 20mg was that CA MTUS guidelines do not support the use of proton pump inhibitors in the absence of GI upset or presentation of risk factors for a GI bleed. The rationale for denial of the request for Orphenadrine ER 100mg was that CA MTUS guidelines do not support the chronic use of muscle relaxants. The rationale for denial of the request for Medrox Pain Relief Ointment was that CA MTUS guidelines do not support the use of topical analgesics in this case. Nor is there documentation of any analgesic effect with the use of Medrox Pain Relief Ointment. The rationale for denial of the request for Hydrocodone (Norco 5/325) was that CA MTUS guidelines require documentation of ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects for

patients on chronic opioid therapy. There were no visual analog scale (VAS) pain scores, nor documentation of any functional or vocational benefit with the ongoing use of the opiate.

IMR ISSUES, DECISIONS AND RATIONALES

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

OMEPRAZOLE DR 20MG CAPSULE SIG: QTY 30.00 WITH 2 REFILLS: Overturned

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

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

Decision rationale: CA MTUS and the FDA support proton pump inhibitors in the treatment of patients with GI disorders such as gastric/duodenal ulcers, GERD, erosive esophagitis, or patients utilizing chronic NSAID therapy. On a 4/28/14 progress report the patient continued to complain of ongoing problems with reflux, stomach burning, and upper gastrointestinal symptoms. The report documents an adequate response of the symptoms to the use of Omeprazole. CA MTUS guidelines do support the use of Omeprazole, proton pump inhibitor, for gastro-esophageal reflux disease. Therefore, the request for Omeprazole DR 20mg capsule SIG: QTY 30.00 with 2 refills is medically necessary.

ORPHENADRINE ER 100MG TABLET, QTY:60 WITH 2 REFILLS: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 63-66.

Decision rationale: CA MTUS Chronic Pain Medical Treatment Guidelines, state that muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in lower back pain (LBP) cases, they show no benefit beyond NSAIDs in pain and overall improvement, and no additional benefit has been shown when muscle relaxants are used in combination with NSAIDs. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. CA MTUS guidelines do not support the chronic use of muscle relaxants; their use is supported short-term only in acute exacerbations of chronic conditions. This patient's date of injury is in 2009 and he has been taken this medication chronically. Furthermore, the reports show that the patient has not improved significantly while using the Orphenadrine. Therefore, the request for Orphenadrine ER 100mg tablet, QTY: 60 with 2 refills are not medically necessary.

MEDROX PAIN RELIEF OINTMENT SIG: APPLY TO AFFECTED AREA TWICE A DAY QTY 60.00 WITH 2 REFILLS: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 25,28, 111-113.

Decision rationale: CA MTUS Chronic Pain Medical Treatment Guidelines state that Ketoprofen, Lidocaine (in creams, lotion or gels), Capsaicin in anything greater than a 0.025% formulation, Baclofen, Boswellia Serrata Resin, and other muscle relaxants, and Gabapentin and other anti-epilepsy drugs are not recommended for topical applications. In addition, any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. CA MTUS guidelines state that topical analgesics are largely experimental with few randomized controlled trials to determine efficacy or safety. Topical analgesics are primarily recommended for neuropathic pain when trials of first-line oral antidepressants and anticonvulsants have failed. Medrox Pain Relief Ointment is a topical formulation of Methyl Salicylate, Menthol, and Capsaicin. The guidelines do not recommend its use. Furthermore, there is no evidence in the reports of any trials of first-line oral agents. Therefore, the request for Medrox Pain Relief Ointment SIG: Apply to affected area twice a day QTY: 60.00 with 2 refills are not medically necessary.

HYDROCODONE (NORCO 5-325) TABLET SIG: TAKE 1 TWICE DAILY QTY:60.00 WITH 1 REFILL: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opiates Page(s): 78-81.

Decision rationale: CA MTUS Chronic Pain Medical Treatment Guidelines do not support ongoing opioid treatment unless prescriptions are from a single practitioner and are taken as directed; are prescribed at the lowest possible dose; and unless there is ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. CA MTUS guidelines require documentation of ongoing review and documentation of pain relief, functional status, appropriate medication use, and discussion of side effects for patients on chronic opioid therapy. There was little evidence of these documentations in the reports. The patients' pain was not measured on a VAS pain scale, and there was little mention of any functional improvement. There is no evidence of lack of aberrant behavior or adverse side effects. On a psychiatric progress report the patient stated he was hearing voices and seeing motorcycles in the air, but the diagnosis of psychosis was never confirmed. This finding was never acknowledged by the prescribing physician. There was no evidence of CURES monitoring, a current opiate contract, or any urine drug screens. Therefore, the request for Hydrocodone (Norco 5/325) tablet SIG: Take 1 twice daily QTY: 60.00 with 1 refill is not medically necessary.

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