

Case Number:	CM15-0005709		
Date Assigned:	01/26/2015	Date of Injury:	08/19/2001
Decision Date:	04/17/2015	UR Denial Date:	01/07/2015
Priority:	Standard	Application Received:	01/12/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: New York

Certification(s)/Specialty: Pediatrics, Internal Medicine

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 injured worker is a 60 year old female, who sustained an industrial injury on August 19, 2001. The injured worker has reported neck and back pain. The diagnoses have included cervical spondylosis without myelopathy, lumbago and long-term use of current medications. Treatment to date has included pain medication, physical therapy, massage therapy, chiropractic treatment and acupuncture all of which provided temporary relief. Current documentation dated December 30, 2014 notes that the injured workers physical examination revealed facet tenderness of the cervical spine. Axial loading of the cervical spine was noted to worsen the pain. Cervical range of motion was decreased. A lumbar examination was not noted. On January 7, 2015 Utilization Review non-certified requests for Lidocaine 5% # 30 with 4 refills, Arthrotec 50 mg # 90 with 3 refills, Prevacid 30 mg # 60 with 4 refills and Colace 100 mg, # 60 with 3 refills and modified Norco 10/325 mg # 60 and Ambien 10 mg # 30. The MTUS, Chronic Pain Medical Treatment Guidelines and Official Disability Guidelines, were cited. On January 12, 2015, the injured worker submitted an application for IMR for review of Lidocaine 5% # 30 with 4 refills, Arthrotec 50 mg # 90 with 3 refills, Prevacid 30 mg # 60 with 4 refills, Colace 100 mg, # 60 with 3 refills, Norco 10/325 mg # 60 and Ambien 10 mg # 30.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325 MG #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use; 4) On-Going Management; 6) When to Discontinue Opioids; 7) When to Continue Opioids, Opioids for chronic pain Page(s): 78-80.

Decision rationale: The IW has been on long term opioids, which is not recommended. Additionally, documentation did not include 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. This request is not medically necessary and reasonable at this time.

Ambien 10 MG #30: Upheld

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

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

Decision rationale: Per ODG pharmacological agents for insomnia should only be used after careful evaluation of potential causes of sleep disturbance for the etiology. Ambien is indicated for the short-term treatment of insomnia with difficulty of sleep onset (7-10 days). Ambien CR is indicated for treatment of insomnia with difficulty of sleep onset and/or sleep maintenance. There is no discussion of an investigation into the origin of the sleep disturbance and non-pharmacological interventions that may have been utilized. Due to adverse effects, FDA now requires lower doses for zolpidem. The dose of zolpidem for women should be lowered from 10 mg to 5 mg for IR products. This request is not medically necessary and appropriate.

Lidocaine 5 Percent #30 with 4 Refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112.

Decision rationale: According to MTUS guidelines topical lidocaine is indicated for neuropathic pain. It is recommended for localized peripheral pain after there has been evidence

of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). There is evidence that the IW had been on an SNRI but there was no definitive evidence of neuropathy such as an EMG/NCV. This request is not medically necessary and appropriate at this time.

Arthrotec 50 MG #90 with 3 Refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) NSAIDs, GI symptoms & cardiovascular risk Page(s): 67-71.

Decision rationale: Arthrotec is indicated for the treatment of the signs and symptoms of osteoarthritis in patients at high risk for developing NSAID-induced gastric or duodenal ulcers and their complications. There is no notation of the IW having osteoarthritis. Additionally, there is notation of the IW having NSAID gastritis but no notation of symptoms or that the combination medication assisted with symptoms of gastritis. This request is not medically necessary and appropriate at this time.

Prevacid 30 MG #60 with 4 Refills: Upheld

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

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

Decision rationale: The indication for proton pump inhibitor use is intermediate or high risk of GI side effects. The risk factors include age > 65 years, history of peptic ulcer, GI bleeding or perforation, concurrent use of ASA, corticosteroids, and/or an anticoagulant and or high dose/multiple NSAID. There was no notation of GI symptoms or a history of risk factors. This request is not medically necessary or appropriate at this time.

Colace 100 MG #60 with 3 Refills: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation uptodate.com.

Decision rationale: Colace is indicated for use as a stool softener. The IW may have hard stools or constipation due to use of narcotics however, there was no notation in the progress notes. The request is not medically necessary and appropriate at this time.