

Case Number:	CM15-0188149		
Date Assigned:	09/30/2015	Date of Injury:	08/05/2013
Decision Date:	12/28/2015	UR Denial Date:	09/23/2015
Priority:	Standard	Application Received:	09/24/2015

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, California Certification(s)/Specialty: Emergency 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:

The injured worker is a 31 year old female, who sustained an industrial injury on 8-5-13. The injured worker was diagnosed as having lumbago, sciatica and thoracic or lumbosacral neuritis or radiculitis. Subjective findings (3-2-15, 3-31-15 and 5-27-15) indicated 6 out of 10 pain in her lower back and left lower extremity. The treating physician noted the injured worker was temporarily totally disabled. Objective findings (3-2-15, 3-31-15 and 5-27-15) revealed lumbar facet loading on the left side and a positive straight leg raise test on the left at 45 degrees in the sitting position. As of the PR2 dated 7-20-15, the injured worker reports pain in her lower back and left lower extremity. She rates her pain 6 out of 10 and stated that her pain is adequately managed with current medication regime. Objective findings include positive lumbar facet loading on the left side and a positive straight leg raise test on the left at 45 degrees in the sitting position. Current medications include Soma (since at least 3-2-15), Ibuprofen (since at least 3-2-15), Percocet (since at least 3-2-15), Gabapentin (since at least 3-2-15) and Pantoprazole (since at least 7-20-15). Treatment to date has included physical therapy x 24 sessions, acupuncture x at least 4 sessions and Omeprazole. The urine drug screen dated 7-22-15 was inconsistent for prescribed medications. The Utilization Review dated 9-23-15, non-certified the request for Ibuprofen 800mg #60, Gabapentin 600mg #90 x 1 refill and Pantoprazole 20mg #60 and modified the request for Soma 350mg #60 and Percocet 7.5-325mg #180 to Soma 350mg #30 and Percocet 7.5-325mg #75.

IMR ISSUES, DECISIONS AND RATIONALES

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

Soma 350mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Carisoprodol (Soma).

Decision rationale: According to CAMTUS, Carisoprodol (Soma) is not recommended. Additionally, it is not recommended for long term use. Medical records support the IW has been taking this medication for a minimum of 3 months. The request does not include frequency or dosing. As this medication is not supported by guidelines, the request for Soma is determined not medically necessary

Ibuprofen 800mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steroidal anti-inflammatory drugs), NSAIDs, specific drug list & adverse effects.

Decision rationale: According to CA MTUS chronic pain guidelines, non-steroidal anti-inflammatory agents are recommended as an option for short term symptomatic relief for the treatment of chronic low back pain. Further recommendations are for the lowest dose for a minimal duration of time. Specific recommendations for ibuprofen (Motrin) state sufficient clinical improvement should be observed to offset potential risk of treatment with the increase dose. The documentation does not support improvement of symptoms with NSAIDs currently prescribed. Additionally, the request does include frequency and dosing of this medication. The request for ibuprofen 800mg is determined medically not necessary.

Percocet 75/325mg #180: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain, Opioids, specific drug list.

Decision rationale: CA MTUS, chronic pain guidelines, offer very specific guidelines for the ongoing use of narcotic pain medication to treat chronic pain. These recommendations state that the lowest possible dose be used as well as ongoing review and documentation of pain relief, functional status, appropriate medication use and its side effects. It also recommends that

providers of opiate medication document the injured worker's response to pain medication including the duration of symptomatic relief, functional improvements, and the level of pain relief with the medications. The included documentation fails to include the above recommended documentation. There is no clear documentation of functional improvement from the use of this medication. There is toxicology results included in the record that show inconsistent results. These discrepancy are not discussed no did prescribing habits change. In addition, the request does not include dosing frequency or duration. The request for Percocet is determined not medically necessary.

Gabapentin 600mg #90 with 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antiepilepsy drugs (AEDs).

Decision rationale: According to CA MTUS, Gabapentin is an anti-epilepsy drug which has efficacy for diabetic neuropathy or post-herpetic neuropathy. It has also been considered a first line agent for neuropathic pain. There is not sufficient evidence to recommend the use of these mediations for the treatment of chronic non-specific, non-neuropathic axial low back pain. Ongoing use of these medications recommends documentation of pain relief and improvement in function as well as documentation of side effects incurred with use. The continued use of AEDs depends on improved outcomes versus tolerability of adverse effects. The IW does not have diabetic neuropathy or post-herpetic conditions. The documentation reports improvement of pain with the use of medications, but specific responses to individual medications is not noted in the record. Additionally, the request does not include dosing frequency. Without this documentation, the request for Gabapentin is not medically necessary in accordance with MTUS guidelines.

Pantoprazole sodium 20mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk.

Decision rationale: According to CA MTUS, gastrointestinal protectant agents are recommended for patients that are at increased risk for gastrointestinal events. These risks include age >65, history or gastrointestinal bleeding or peptic ulcers, concomitant use of NSAIDs and corticosteroids or aspirin, or high dose NSAID use. The chart does not document any of these risk factors. Past medical history does not include any gastrointestinal disorders, there is no history of poor tolerance to NSAIDs documented and there are no abdominal examinations noted in the chart. Pantoprazole is not medically necessary based on the MTUS.