

Case Number:	CM15-0027790		
Date Assigned:	03/18/2015	Date of Injury:	05/12/2003
Decision Date:	04/24/2015	UR Denial Date:	01/19/2015
Priority:	Standard	Application Received:	02/13/2015

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: Illinois, California, Texas Certification(s)/Specialty: Orthopedic Surgery

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 51-year-old male who sustained an industrial injury on 5/12/03 from a slip and fall landing on his buttocks and experiencing immediate pain in his low back. Past medical history was positive for gastroesophageal reflux disease, hypertension, diabetes mellitus, and sleep apnea. The 12/15/14 treating physician report cited grade 7/10 low back pain with constant left lower extremity numbness and tingling, left buttock aching, burning, and pins and needles, and grade 8/10 burning left leg and ankle pain. Physical exam documented mild antalgic gait on the left, and abnormal left heel/toe walk. Lumbar exam documented left paraspinal and midline tenderness, left muscle spasms, bilateral sacroiliac tenderness with compression, and positive sciatic nerve compression on the left. There was moderate to marked restriction in lumbar range of motion in all planes. Straight leg raise was positive on the left. Sensation was decreased over the left posterolateral calf and foot, ankle reflexes were 1+ bilaterally, and patellar reflexes were +2 bilaterally. There was 4/5 plantar flexion and toe extension weakness on the left. The diagnosis was L4/5 and L5/S1 degenerative discopathy with facet syndrome, sleep disturbance, depression, and obesity. The treatment plan recommended posterior lumbar interbody fusion at L4/5 and L5/S1 and various associated surgical items and services. Medication management noted the reclassification of Norco and recommended reducing Norco to 45 per month, and then alternate this with Ultram. Additional medications were prescribed including alprazolam for anxiety, zolpidem for sleep, and transdermal medications was prescribed for symptomatic relief. Norco was reported as effective because it reduced the pain to the point where it allows the injured worker to perform some activities of daily living. The 1/19/15 utilization review non-certified a request for Ultram 50 mg #60 with one refill, as there was no support to suggest a need to progress beyond first-line analgesics. The request for Alprazolam 1 mg #30 with one refill was non-certified as this medication had been prescribed for years with no

current description of anxiety to support on-going need, and this medication had not been recommended since December 2013. The request for Zolpidem 10 mg #30 with one refill was non-certified as this medication had been prescribed since 2011 with no documented improvement in sleep symptoms, and there was an absence of guideline support for long-term use. The request for Norco 10/325 #45 was non-certified as there was no documented evidence of quantifiable pain relief or functional improvement despite long-term use since 2011, and weaning had been recommended since 3/5/14. The request for compounded topical medications was non-certified as all components were not recommended. The 2/6/15 appeal letter stated that the injured worker was taking Norco and Ultram and stated that Norco was helping him. He had been alternating Norco with Ultram, and Ultram was not beneficial. The amount of Norco had been cut down from 120 to 90 to 25 pills per month. The other medications were not discussed in the appeal.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ultram 50mg #60 with 1 refill: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use, Tramadol Page(s): 76-80, 93-94, 113.

Decision rationale: The California MTUS indicate that opioids, such as Ultram, are recommended for moderate to moderately severe pain. Ultram is an opioid analgesic and is not recommended as a first line oral analgesic. If used on a long-term basis, the criteria for use of opioids should be followed. Guidelines suggest that opioids be discontinued if there is no overall improvement in function, unless there are extenuating circumstances. Guideline criteria have not been met for use of this medication. The patient reported no benefit with the addition of Ultram, and the medical necessity of an additional opioid medication was not established. Therefore, this request is not medically necessary.

Alprazolam 1mg #30 with 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chronic - Alprazolam, Insomnia treatment.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

Decision rationale: The California Chronic Pain Medical Treatment Guidelines do not recommend the long-term use of benzodiazepines, such as Alprazolam, because long-term efficacy is unproven and there is a risk of dependence. MTUS guidelines limit their use to 4 weeks and indicate that they are the treatment of choice in very few conditions. Guideline criteria have not been met. There is no current documentation of anxiety or benefit to this medication to support continued use. The patient has been using this medication for years and discontinuation has been recommended since December 2013. There is no compelling reason to support the continued use of alprazolam in the absence of guideline support. Therefore, this request is not

medically necessary.

Zolpidem 10mg #30 with 1 refill: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic): Ambien (zolpidem tartrate); Zolpidem (Ambien).

Decision rationale: The California Medical Treatment Utilization Schedule does not make recommendations relative to zolpidem or insomnia treatment. The Official Disability Guidelines recommend Zolpidem for short-term (7-10 days) treatment of insomnia. Guidelines recommend that insomnia treatment be based on the etiology. Pharmacological agents should only be used after careful evaluation of potential causes of sleep disturbance. The specific components of insomnia should be addressed including sleep onset, sleep maintenance, sleep quality and next-day functioning. Guideline criteria have not been met. Records indicate that the patient has been using this medication since 2011. There is no current documentation of the specific components of insomnia. There is no compelling rationale to support the medical necessity of continued use in the absence of guideline support for long-term use. Therefore, this request is not medically necessary.

Norco 10/325mg #45: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Hydrocodone/Acetaminophen, Opioids, criteria for use / chronic pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use, Hydrocodone/acetaminophen Page(s): 76-81, 91.

Decision rationale: The California MTUS guidelines support the use of hydrocodone/acetaminophen (Norco) for moderate to moderately severe pain on an as needed basis. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. On-going management requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. Guidelines suggest that opioids be discontinued if there is no overall improvement in function, unless there are extenuating circumstances. Guideline criteria have not been met for the on-going use of Norco. This medication has been used since 2011 and weaning has been recommended since March 2014. There is no current documentation relative to specific pain reduction or objective measurable functional improvement with this use of this medication. Additionally, records indicate that progressive weaning has occurred with no documentation of adverse effect on pain or function. Therefore, this request is not medically necessary.

One (1) prescription of Flurbi/Bacle/Cyclo 20/2/2% #120gm: Upheld

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

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

Decision rationale: The California MTUS state that any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Guidelines indicate that topical analgesics in general are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Flurbiprofen is not on the list of approved topical non-steroidal anti-inflammatory drugs. Guidelines state there is no evidence for use of a muscle relaxant, such as cyclobenzaprine, as a topical product. Baclofen is not recommended for topical use. Given the absence of guideline support for all components of this topical cream, this request is not medically necessary.

One (1) prescription of Keto/Gaba/Diclo 15/8/5/5% #120: Upheld

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

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

Decision rationale: The California MTUS state that any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Guidelines indicate that topical analgesics in general are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Ketoprofen is not currently FDA approved for a topical application and has an extremely high incidence of photocontact dermatitis. Topical gabapentin is not recommended by the guidelines. Diclofenac is recommended for short term use in a 1% formulation for osteoarthritis, but is not recommended for treatment of the spine or neuropathic pain. Given the absence of guideline support for all components of this topical cream, this request is not medically necessary.