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| Case Number: | CM15-0030372 | | |
| Date Assigned: | 02/24/2015 | Date of Injury: | 10/23/2012 |
| Decision Date: | 04/07/2015 | UR Denial Date: | 02/02/2015 |
| Priority: | Standard | Application Received: | 02/18/2015 |

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: California, Massachusetts
 Certification(s)/Specialty: Preventive Medicine, Occupational 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 44 year old male, who sustained an industrial injury on 10/23/2012. He has reported carrying air conditioning units on the day of injury and upon placing a unit down he experienced pain to the low back that radiated into the legs. Diagnoses include magnetic resonance imaging evidence of multi-level annual tears lumbar four through sacral one, grade I lumbar five through sacral one retrolisthesis with annular tear, and electromyogram evidenced right sacral one and possible left lumbar five radiculopathies. Treatment to date has included medication regimen, magnetic resonance imaging, electromyogram, chiropractic care, acupuncture, physical therapy, and epidural injections. In a progress note dated 01/21/2015 the treating provider reports pain that is rated a six out of ten and radiating right lower extremity pain. The treating physician requested the medications of a Stool Softener for opiate induced constipation along with Norco and Celebrex for pain management. On 02/02/2015 Utilization Review non-certified the requested treatments of Stool Softener one by mouth up to twice a day for a quantity of 60, Norco 7.5/325mg one tablet daily for a quantity of 30, and Celebrex 200mg one tablet by mouth daily with a quantity of 30 with one refill, noting the California Medical Treatment Utilization Schedule, 2009, Chronic Pain Medical Treatment Guidelines, pages 77 to 80, page 124, page 67 to 68, and page 70.

IMR ISSUES, DECISIONS AND RATIONALES

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

Stool Softener 1 by mouth, up to two (2) times per day, #60: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use; Weaning of Medications Page(s): 78-80, 124.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for use, page(s) 76-96.

Decision rationale: The IW has been treated with opioids with side effect of constipation. According to treatment guidelines stool softener is appropriate treatment both empirically prior to initiating opioid therapy as well as when there are reported symptoms of constipation. Consequently stool softener is an appropriate treatment throughout the duration of opioid therapy.

Norco 7.5/325mg 1 tablet everyday, #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, specific drug list Page(s): 91.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for use, page(s) 76-96.

Decision rationale: CA MTUS guidelines require that criteria for continued long-term use of opioids require ongoing review and documentation of pain relief, functional status improvement, appropriate use, screening of side effects and risk for abuse, diversion and dependence. From my review of the provided medical records there is lacking a description of quantifiable improvement with ongoing long-term use of short acting opioids such as the prescribed medication. VAS score has stayed unchanged with no noted improvement in objective physical exam findings or functional capacity. The provider has ordered UDS but there is no report of whether or not UDS was appropriate. Consequently continued use of short acting opioids is not supported by the medical records and guidelines as being medically necessary. If there is improvement with the prescribed treatment and UDS are appropriate than treatment would be appropriate; without this information documented in the clinical record the treatment is not supported.

Celebrex 200mg 1 tab by mouth everyday, #30 with 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 67-68, 70.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAID Page(s): 67-73.

Decision rationale: NSAIDs are an appropriate first line treatment for chronic back pain. However, first option should be generic ibuprofen or naproxyn. Celebrex is aCOX-2 NSAID

and should be reserved for patients with contraindications such as gastritis or GI ulcer. Unfortunately there was nothing documented in the records provided that support use of celebrex over generic naproxyn.