

Case Number:	CM15-0081543		
Date Assigned:	05/04/2015	Date of Injury:	01/04/2004
Decision Date:	06/24/2015	UR Denial Date:	03/30/2015
Priority:	Standard	Application Received:	04/28/2015

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: Anesthesiology

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 46 year old male, who sustained an industrial injury on January 4, 2004. He reported feeling a pop in his lower back and increased back pain. The injured worker was diagnosed as having low back pain, lumbar disc displacement, lumbar radiculopathy, post-laminectomy syndrome of lumbar region, and hypertension. Diagnostics to date has included MRI, CT, x-rays, and blood work. Treatment to date has included aquatic therapy, physical therapy, psychotherapy, acupuncture, a home exercise program, a transcutaneous electrical nerve stimulation (TENS) unit, ice, heat, lumbar epidural steroid injections, and medications including oral and transdermal opioid, muscle relaxant, anti-epilepsy, non-steroidal anti-inflammatory, anti-ulcer, histamine H2-receptor, and a combination angiotensin-converting enzyme (ACE) inhibitor/diuretic. On March 9, 2015, the injured worker complains of chronic, sharp and shooting low back pain, which is now in the midline area. The pain radiates into both legs with numbness tingling, electric jolts of the knees, edema of the bilateral knees and ankles, and mild weakness. He complains of continued right testicle swelling with severe back pain. He has difficulty walking due to back pain and prolonged standing worsens the pain. He is able to perform his activities of daily living with the use of his medications. His pain level was rated as 7/10. The injured worker reports no significant changes since the prior visit. The physical exam revealed a normal gait, difficulty heel walking due to pain, bilateral paralumbar spasm and tenderness, quadriceps atrophy, decreased range of motion with pain, diminished bilateral resisted rotation, positive bilateral straight leg raise, absent deep tendon reflexes at the bilateral ankles, and decreased sensation in the bilateral lateral and dorsal foot. There was normal motor strength of the bilateral lower extremities. The treatment plan includes Norco 5/325mg, Diclofenac 75mg, Cimetidine 400mg, Carafate 1 Gram, Fentanyl 25mcg, Neurontin 300mg, and Benazepril Hydrochlorothiazide.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 5/325mg quantity 90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for the treatment of chronic pain Page(s): 91-97. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Opioids.

Decision rationale: According to the CA MTUS and ODG, Norco 5/325mg (Hydrocodone/Acetaminophen) is a short-acting opioid analgesic indicated for moderate to moderately severe pain, and is used to manage both acute and chronic pain. The treatment of chronic pain with any opioid analgesic requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. A pain assessment should include current pain, intensity of pain after taking the opiate, and the duration of pain relief. In this case, there is no documentation of the medication's functional benefit. Medical necessity of the requested item has not been established. Of note, discontinuation of an opioid analgesic should include a taper, to avoid withdrawal symptoms. The requested medication is not medically necessary.

Diclofenac 75mg quantity 60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-71. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) NSAIDs.

Decision rationale: According to California MTUS Guidelines, oral NSAIDs, such as Diclofenac, are recommended for the treatment of chronic pain and control of inflammation as a second-line therapy after acetaminophen. The ODG states that NSAIDs are recommended for acute pain, acute low back pain (LBP), and short-term pain relief in chronic LBP. There is no evidence of long-term effectiveness for pain or function. According to the ODG, there is inconsistent evidence for the use of NSAIDs to treat long-term neuropathic pain, but they may be useful to treat breakthrough pain in this condition. In addition, physicians should measure transaminases periodically in patients receiving long-term therapy with Diclofenac. In this case, there is no documentation of significant reduction of pain or functional benefit in the past. Medical necessity for the requested medication has not been established. The requested item is not medically necessary.

Cimetidine 400mg quantity 60: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.drugs.com/mtm/climetidine.html>.

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

Decision rationale: Cimetidine (Tagamet) is a histamine blocker (H₂-receptor antagonist) that inhibits stomach acid production. It is an antacid used to treat peptic ulcers, gastritis and gastroesophageal reflux (GERD). Cimetidine works by blocking the effects of histamine on the receptor site known as H₂. In this case, there is documentation indicating the patient has severe GERD. Therefore, medical necessity for Cimetidine has been established. The requested medication is medically necessary.

Carafate 1gm quantity 120: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.drugs.com/carafate.html>.

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

Decision rationale: Carafate (Sucralfate) is a cytoprotective agent indicated for the treatment of duodenal ulcers, stress ulcers and gastrointestinal reflux diseases (GERD). Unlike other medications used for the treatment of peptic ulcer disease, Carafate is a sucrose sulfate-aluminum complex that binds to the mucosa, thus creating a physical barrier that impairs diffusion of hydrochloric acid in the gastrointestinal tract and prevents degradation of mucus by acid. In this case, there is documentation indicating the patient has severe GERD. The medical necessity for Carafate has been established. The requested medication is medically necessary.

Fentanyl 25mcg quantity 4: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Duragesic (fentanyl transdermal system).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for the treatment of chronic pain Page(s): 91-97. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Opioids.

Decision rationale: According to the ODG and CA MTUS, Fentanyl is a long-acting narcotic analgesic used to manage both acute and chronic pain. Fentanyl is an opioid analgesic with a potency of eighty times that of Morphine. Fentanyl transdermal (Duragesic) patches are indicated for the management of persistent chronic pain, which is moderate to severe requiring continuous, around-the-clock opioid therapy. Duragesic patches should only be used in patients who are currently on opioid therapy for which tolerance has developed. Patches are worn for a 72-hour period. In this case, the treatment of chronic pain with any opioid analgesic requires

review and documentation of pain relief, functional status, appropriate medication use, and side effects. A pain assessment should include current pain, intensity of pain after taking the opiate, and the duration of pain relief. There is no documentation of the medication's pain relief effectiveness, functional status, or response to ongoing opioid analgesic therapy. Medical necessity of the requested item has not been established. Of note, discontinuation of an opioid analgesic should include a taper to avoid withdrawal symptoms. The requested medication is not medically necessary.

Neurontin 300mg quantity 90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin (Neurontin).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs (AEDs) Page(s): 17-19.

Decision rationale: Neurontin (Gabapentin) is an anti-epilepsy drug which has been shown to be effective for treatment of diabetic painful neuropathy and post-herpetic neuralgia and has been considered as a first-line treatment for neuropathic pain. The records document that the patient has reported radiculopathy related to his chronic low back condition, without evidence of neuropathic pain. There was no documentation of objective findings consistent with current neuropathic pain to necessitate use of Neurontin. Medical necessity for Neurontin has not been established. The requested medication is not medically necessary.

Benazaperil Hydrochlorothiazide 20-25mg quantity 30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.drugs.com/mtm/hydrochlorothiazide-and-benazepril.html>.

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

Decision rationale: Benazepril (Lotensin) is a drug of the angiotensin-converting enzyme (ACE) inhibitor class used primarily for the treatment of hypertension, congestive heart failure, and myocardial infarctions. It is also used for preventing renal and retinal complications of diabetes. It can be combined with a diuretic to increase efficacy. In this case, the patient has a diagnosis of hypertension but there is no documentation of his blood pressure readings on this medical therapy. Medical necessity for the requested medication has not been established. The requested medication is not medically necessary.