

Case Number:	CM14-0119554		
Date Assigned:	09/16/2014	Date of Injury:	11/16/2006
Decision Date:	10/22/2014	UR Denial Date:	07/16/2014
Priority:	Standard	Application Received:	07/28/2014

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in Nevada. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 47-year-old male who was reportedly injured on November 16, 2006. The most recent progress note dated August 21, 2014, indicates that there were ongoing complaints of neck and low back pain. The physical examination demonstrated a hypertensive (140/88) individual with a decreased right shoulder range of motion, tenderness to palpation about the cervical spine, and a normal cervical spine range of motion. There was tenderness to palpation in the lower lumbar region and a decrease in lumbar spine range of motion. Diagnostic imaging studies noted the postsurgical changes. Previous treatment includes lumbar fusion surgery, multiple medications, injection therapy, epidural steroid injections, physical therapy, and other pain management interventions. A request was made for multiple medications and was not certified in the pre-authorization process on July 16, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Miralax Oral Powder (#60 with 3 refills): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use, Initiating Therapy.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Clin Colon Rectal Surg. May 2005; 18(2): 76-80.

Constipation and Functional Bowel Disease Medical Treatment of Constipation Jonathan D. Siegel, M.D.¹ and Jack A. Di Palma, M.D.¹

Decision rationale: Miralax is a commercial, over-the-counter product, indicated to treat occasional constipation. The ACOEM Practice Guidelines, California MTUS Guidelines or the Official Disability Guidelines do not address this topic. A literature review notes that this medication is indicated for occasional use. It would appear that there is a chronic constipation problem. However, there are no physical examination findings presented to support this. Therefore, based on the insufficient clinical examination tempered by the clinical indication for this product. There is insufficient information presented to establish the medical necessity.

MS Contin (60mg, #60): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MS Contin, Opioids, criteria for use, On-Going Management.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-75, 78, 93.

Decision rationale: The California MTUS Guidelines support long-acting opiates in the management of chronic pain when continuous around-the-clock analgesia is needed for an extended period of time. Management of opiate medications should include the lowest possible dose to improve pain and function, as well as the ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects. The claimant suffers from chronic pain; however, there is no documentation of improvement in their pain level or increase in the overall functionality with the current treatment regimen. Furthermore, previous progress notes have indicated that this medication has been replaced with an oral tablet (oxycodone) and that was endorsed in the preauthorization process. Accordingly, this request is not medically necessary.

Norco (10/325mg, #180 with 1 refill): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-78, 88, 91.

Decision rationale: A review of the progress notes indicate that there is little efficacy with this medication. Furthermore, it is also noted that a separate analgesic medication (oxycodone) have been certified in the preauthorization process. The current progress indicates that an opioid contract I signed, and for receptor being followed. However, the additional medication of OxyContin was not addressed. Therefore, given the disjointed nature of the progress notes, there is insufficient clinical information presented to support the medical necessity of this medication.

Prilosec (20mg, #60 with 3 refills): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk.

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

Decision rationale: As noted in the literature, this is a proton pump inhibitor useful in the treatment of gastroesophageal reflux disease and can be considered as a protectorate for those individuals utilizing non-steroidal medications. However, the progress notes did not indicate any ongoing complaints of gastrointestinal distress, gastritis, and there are no physical examination findings to support the same. As such, there is insufficient clinical information presented to support the medical necessity of this request.

Senna (8.6mg, #90 with 3 refills): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use, Initiating Therapy.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation McQuaid KR. Chapter 15. Gastrointestinal Disorders. In: Papadakis MA, McPhee SJ, Rabow MW. eds. CURRENT Medical Diagnosis & Treatment 2014. New York, NY: McGraw-Hill; 2014

Decision rationale: Senna is a vegetable laxative not addressed by the California MTUS Guidelines, the ACOEM Practice Guidelines or the Official Disability Guidelines. The leaves of the senna plant contain sennosides that irritate the lining of the bowel causing a laxative effect. The literature notes that this is a laxative indicated for the short-term treatment of symptomatic constipation. Review of the available medical records documents long-term use for this claimant. As such, it is not considered medically necessary.

Klonopin (1mg, #60 with 3 refills): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Mental Illness & Stress, Anxiety Medication

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antispasticity/Antispasmodic Drugs, Benzodiazepines Page(s): 66.

Decision rationale: Clonazepam (aka Klonopin) is a benzodiazepine used for the treatment of anxiety, seizures, neuralgia, and periodic leg movement disorder. It is not recommended for long term use. Further, as noted in the MTUS, this is not recommended due to rapid development of tolerance of dependence issues. There is little benefit in the use of this class of medications over non-benzodiazepines are the treatment spasm. Therefore, ongoing use of this medication is not supported. The medical necessity cannot be determined.

Metoprolol Tartrate (25mg, #60 with 3 refills): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Institute for Clinical Systems Improvement (ICSI); 2012 Nov. 67 p.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation "Effect of Metoprolol CR/XL in Chronic Heart Failure: Metoprolol CR/XL Randomised Intervention Trial in Congestive Heart Failure (MERIT-HF)". Lancet 353 (9169): 2001-2007.

Decision rationale: This is an antihypertensive medication. The management of hypertension is a complex situation requiring multiple data points. Furthermore, a review of the literature notes that a more appropriate intervention would be an angiotensin-converting enzyme (ACE) inhibitor. The progress notes presented for review do not provide a comprehensive analysis of the efficacy of this medication. As such, there is insufficient clinical information presented in the progress note support this request. This is not medically necessary based on the data presented.

Mobic (7.5mg, #60 with refills): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, specific drug list & adverse effects, Meloxicam (Mobic, g.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, specific drug list & adverse effects, Meloxicam (Mobic, generic available) Page(s): 72.

Decision rationale: This is a non-steroidal anti-inflammatory medication. As outlined in the California MTUS Guidelines, this is a first-line treatment to reduce pain and inflammation. However, when considering the date of injury, the multiple treatments rendered, and the lack of any objectification of any efficacy or utility with this particular preparation, there is insufficient clinical information presented to support the ongoing use of this medication..

Topamax (100mg, #60 with 1 refill): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs (AEDs), Topiramate (Topamax)..

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs (AEDs), Topiramate (Topamax). Page(s): 21.

Decision rationale: As noted in the California MTUS Guidelines, this medication is shown to have some variable efficacy in the treatment of neuropathic pain. However, the medical records do not objectify any efficacy or functional utility with the use of this medication. Therefore, based on the incomplete clinical assessment and records provided, there is insufficient evidence to establish the medical necessity of this medication.

Maxalt (10mg, #9 with 1 refill): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Head, Rizatriptan (Maxalt).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Head Chapter, (Updated August, 2014).

Decision rationale: This medication is not addressed in the California MTUS Guidelines or the ACOEM Practice Guidelines. The parameters noted in the Official Disability Guidelines were employed. This medication is used to treat migraine headaches. It is also noted that this medication had been endorsed in the preauthorization process. Therefore, it is unclear why an additional request is being made at this time. As such, the medical necessity of additional prescriptions is not been established.

Neurontin (300mg, #120 with 1 refill): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs), Gabapentin (Neurontin) Page(s): 16-20, 49.

Decision rationale: The California MTUS Guidelines supports Neurontin for treatment of diabetic painful neuropathy and post-herpetic neuralgia and has been considered as a first-line treatment for neuropathic pain. Review of the available medical records documents chronic back pain; however, the claimant has no objective findings of neuropathic or radicular on examination. Furthermore, there is no objectified data to suggest any increase in overall functionality or decrease in pain symptomology. Therefore, the efficacy of this medication has not been established. As such, this request does not meet guideline criteria and is therefore not considered to be medically necessary.