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| Case Number: | CM14-0130122 | | |
| Date Assigned: | 08/20/2014 | Date of Injury: | 03/05/2003 |
| Decision Date: | 09/25/2014 | UR Denial Date: | 08/06/2014 |
| Priority: | Standard | Application Received: | 08/14/2014 |

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 California. 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:

According to the records made available for review, this is a 63-year-old male with a 3/5/03 date of injury. There is documentation of subjective (lower back pain radiating to left lower extremity) and objective (decreased lumbar spine range of motion, positive left straight leg raising test, depressed left ankle reflex, and decreased sensation to pinprick at left lateral calf and left lateral foot) findings. Current diagnoses include lumbago and pain in limb. Treatment to date includes medication and acupuncture.

IMR ISSUES, DECISIONS AND RATIONALES

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

AMBIEN 10MG #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES.

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

Decision rationale: ODG identifies Ambien (zolpidem) as a prescription short-acting nonbenzodiazepine hypnotic, which is approved for the short-term (usually two to six weeks)

treatment of insomnia. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of lumbago and pain in limb. In addition, there is documentation of ongoing treatment with Ambien. However, there is no documentation of insomnia. Furthermore, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Ambien use to date. Therefore, based on guidelines and a review of the evidence, the request is not medically necessary.

ANAPROX DS 550MG #60: Upheld

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

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

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of moderate to severe osteoarthritis pain, acute low back pain, chronic low back pain, or exacerbations of chronic pain, as criteria necessary to support the medical necessity of NSAIDs. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of lumbago and pain in limb. In addition, there is documentation of ongoing treatment with Anaprox. However, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Anaprox use to date. Therefore, based on guidelines and a review of the evidence, the request is not medically necessary.

HYDROCODONE/APAP 10/325MG #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-80.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines necessitate documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of

pain relief, functional status, appropriate medication use, and side effects, as criteria necessary to support the medical necessity of opioids. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of lumbago and pain in limb. In addition, there is documentation of ongoing treatment with Hydrocodone/APAP. However, there is no documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. In addition, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Hydrocodone/APAP use to date. Therefore, based on guidelines and a review of the evidence, the request is not medically necessary.

PRILOSEC 20MG #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68-69. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), Proton pump inhibitors (PPIs).

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies that risk for gastrointestinal event includes age > 65 years; history of peptic ulcer, GI bleeding or perforation; concurrent use of ASA, corticosteroids, and/or an anticoagulant; and/or high dose/multiple NSAID. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. ODG identifies documentation of risk for gastrointestinal events and preventing gastric ulcers induced by NSAIDs, as criteria necessary to support the medical necessity of Omeprazole. Within the medical information available for review, there is documentation of diagnoses of lumbago and pain in limb. In addition, there is documentation of ongoing treatment with Prilosec with NSAIDs use. However, despite documentation of ongoing treatment with NSAIDs, there is no documentation of risk for gastrointestinal events (high dose/multiple NSAID). Therefore, based on guidelines and a review of the evidence, the request is not medically necessary.

FLURBIPROFEN 25% IN IIDODERM BASE - 30GM TUBE #1: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Non-steroidal anti-inflammatory agents (NSAIDs) Page(s): 111-112. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Topical analgesics.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist) and short-term use (4-12 weeks), as criteria necessary to support the medical necessity of topical NSAIDs. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. ODG identifies documentation of failure of an oral NSAID or contraindications to oral NSAIDs. Within the medical information available for review, there is documentation of diagnoses of lumbago and pain in limb. In addition, there is documentation of ongoing treatment with Flurbiprofen 25% in Lipoderm base. However, there is no documentation of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist) and short-term use (4-12 weeks). In addition, there is no documentation of failure of an oral NSAID or contraindications to oral NSAIDs. Furthermore, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Flurbiprofen 25% in Lipoderm base use to date. Therefore, based on guidelines and a review of the evidence, the request for is not medically necessary.

FLURBIPROFEN 25%-LIDOCAINE 5% IN LIPODERM BASE - 60GM TUBE #1:
Upheld

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

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

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies that many agents are compounded as monotherapy or in combination for pain control; that ketoprofen, lidocaine (in creams, lotion or gels), capsaicin in a 0.0375% formulation, baclofen and other muscle relaxants, and gabapentin and other antiepilepsy drugs are not recommended for topical applications; and that any compounded product that contains at least one drug (or drug class) that is not recommended, is not recommended. Within the medical information available for review, there is documentation of diagnoses of lumbago and pain in limb. In addition, there is documentation of ongoing treatment with Flurbiprofen 25%-Lidocaine 5% in Lipoderm base. However, Flurbiprofen 25%-Lidocaine 5% in Lipoderm base contains at least one component (Lidocaine) that is not recommended. Therefore, based on guidelines and a review of the evidence, the request is not medically necessary.