

Case Number:	CM14-0132331		
Date Assigned:	09/19/2014	Date of Injury:	06/16/2010
Decision Date:	10/24/2014	UR Denial Date:	07/14/2014
Priority:	Standard	Application Received:	08/18/2014

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 & Rehabilitation and is licensed to practice in Illinois. 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 48-year-old female who reported an injury on 06/16/2010. The mechanism of injury was not submitted for review. The injured worker has diagnoses of status post lumbar spine surgery, status post selective nerve root block, lumbar sprain, lumbar myofascial pain, lumbar disc disease, lumbar radiculopathy, lumbar facet arthropathy, and anxiety and depression. Past medical treatment consists of surgery, physical therapy, and medication therapy. On 03/16/2011, the injured worker underwent lumbar spine surgery. On 08/07/2014 the injured worker complained of back pain. It was noted in the physical examination that the injured worker rated the pain at 10+/10. Physical examination of the lumbar spine revealed that the injured worker had allodynia over the lumbar spine. There was tenderness to palpation over the coccyx area and hardware screws as well as tightness, spasms, and tenderness in the paravertebral muscles. The injured worker had a range of motion of lateral bending 25 degrees to the right and 20 degrees on the left, flexion was 40 degrees bilaterally and extension was 10 degrees bilaterally. Sensory examination was decreased over the left L5 distribution. The treatment plan for the injured worker is to continue the use of medication therapy. Urinary drug screen dated 01/14/2014 indicated that the injured worker was in compliance with her medications. The rationale and Request for Authorization form were not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Percocet 10/325mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 92.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Percocet; Ongoing Management Page(s): 75, 86; 78.

Decision rationale: The request for Percocet 10/325mg #30 is not medically necessary. The California MTUS Guidelines recommend Percocet for moderate to severe chronic pain and that there should be documentation of the 4 A's for ongoing monitoring including analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors. It further recommends that dosing of opioids not exceed 120 mg orals morphine equivalents per day, and for patients taking more than 1 opioid, the morphine equivalent doses of the different opioids must be added together to determine the cumulative dose. The guidelines also recommend an assessment showing what pain levels were before, during, and after medication administration. The submitted documentation failed to indicate the efficacy of the medication. There was no indication that the medication was helping with any functional deficits the injured worker might have had. A drug screen was submitted on 01/14/2014 showing that the injured worker was in compliance with medications. However, there was no assessment showing what pain levels were before, during, or after medication. Given the above, the injured worker is not within the MTUS recommended Guidelines. As such, the request is not medically necessary.

Norco 10/325mg #180: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Norco; Ongoing Management Page(s): 75; 78.

Decision rationale: The request for Norco 10/325mg #180 is not medically necessary. The California MTUS Guidelines recommended short acting opioids such as Norco for controlling chronic pain. For ongoing management there should be documentation of the 4 A's including analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors. Pain relief, functional status, appropriate medication use, and side effects. The guidelines also recommend an assessment showing what pain levels were before, during, and after medication administration. The submitted documentation did not indicate the efficacy of the medication. Additionally, it was not documented that the medication was helping with any functional deficits. A drug screen was submitted on 01/14/2014 showing that the injured worker was in compliance with her medications. However, there was no assessment submitted for review showing what pain levels were before, during, or after medication administration. Given the above, the injured worker is not within the MTUS recommended guidelines. As such, the request is not medically necessary.

Xanax 2mg #30: Upheld

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

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

Decision rationale: The request for Xanax 2mg #30 is not medically necessary. The California MTUS Guidelines do not recommend the use of benzodiazepines for long term use because long term efficacy is unproven and there is risk of dependence. Most guidelines limit the use to 4 weeks. It was indicated in the submitted report that the injured worker had been prescribed Xanax since at least 09/12/2013 exceeding the recommended guidelines for short term use. Additionally, the request as submitted is for Xanax 2 mg with a quantity of 30 which is an additional month's supply. Furthermore, there was lack of efficacy of the medication documented to support continued use, and the frequency was also not provided in the request. As such, the request is not medically necessary.

Valium 10mg #30: Upheld

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

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

Decision rationale: The request for Valium 10mg #30 is not medically necessary. According to the CA MTUS, Valium is known generically as diazepam and is a benzodiazepine primarily indicated as a sedative/hypnotic, anxiolytic, anticonvulsant, and muscle relaxant. Benzodiazepines are not recommended due to rapid development of tolerance independence; most guidelines limit the use to 4 weeks. It was noted in the documentation that the injured worker had been on this medication since at least 09/2013, exceeding the recommended guidelines. Additionally, the request as submitted is for Valium 10 mg with a quantity of 30, totaling an additional month of use, again exceeding recommended guidelines for short term use. The efficacy of the medication was not submitted for review to warrant the continuation of the medication. Given the above, the request is not medically necessary.

Carafate 1mg #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.ncbi.nlm.nih.gov/pubmed/6798100>

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Opioid-induced constipation treatment (Carafate).

Decision rationale: The request for Carafate 1mg #30 is not medically necessary. ODG recommends opioid induced constipation treatment upon prescribing an opioid, especially if it

will be needed for more than a few days. There should be an open discussion with the injured worker that opioids may be constipating and the first step should be to identify and correct it. Simple treatment teachings such as including increasing physical therapy, maintaining hydration by drinking enough water, and advising the injured worker to follow a proper diet rich in fiber, can reduce the chance of severity of opioid induced constipation and constipation in general. It was noted in the documentation submitted on 08/07/2014 that the injured worker had no history of peptic ulcer disease, diarrhea, constipation or irritable bowel syndrome. Additionally, there was no rationale provided warranting the use of the medication. Given the above, the injured worker is not within the ODG criteria for the use of Carafate for opioid induced constipation. As such, the request is not medically necessary.