

Case Number:	CM14-0212548		
Date Assigned:	01/02/2015	Date of Injury:	03/30/2000
Decision Date:	02/28/2015	UR Denial Date:	12/03/2014
Priority:	Standard	Application Received:	12/18/2014

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. 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, Hawaii
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 patient is a 60 year old male with date of injury 03/30/00. The treating physician report dated 11/17/14 (14) indicates that the patient presents with pain affecting the low back. The patient states that his right foot has been inverting since surgery. The physical examination findings reveal a decreased range of motion of the lumbar spine accompanied with pain. Further examination reveals spasm on palpation of the lumbar spine. Prior treatment history includes prescribed medications. The patient is currently permanent and stationary. The current diagnosis is: Sprain, lumbar region. The utilization review report dated 12/3/14 (3) denied the request for Retro Protonix 20mg Qty 180, Retro Voltaren XR 100mg Qty 180, Retro Ultram 50mg Qty 180, and Retro Flexeril 7.5mg Qty 270 based on a lack of medical necessity.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retro Protonix 20mg Qty 180: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms & Cardiovascular Risk Page(s): 68.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 68-69.

Decision rationale: The patient presents with pain affecting the low back. The current request is for Retro Protonix 20mg Qty 180. The requesting treating physician report does not provide any rationale for the current request. There is documentation of current NSAID use in the most current progress report provided dated 11/17/14. The MTUS guidelines state Protonix is recommended with precautions, "(1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA)." Clinician should weigh indications for NSAIDs against GI and cardio vascular risk factors, determining if the patient is at risk for gastrointestinal events. In this case, there is documentation provided of current NSAID use but there is no indication that the patient was at risk for gastrointestinal events nor was there any documentation of dyspepsia. The current request does not satisfy MTUS guidelines as outlined on pages 68-69. The request is not medically necessary.

Retro Voltaren XR 100mg Qty 180: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) Page(s): 67-68.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-inflammatory medications, Medications for chronic pain, NSAIDs Page(s): 22, 60, 67-68.

Decision rationale: The patient presents with pain affecting the low back. The current request is for Retro Voltaren XR 100mg Qty 180. The requesting treating physician report does not provide any rationale for the current request. Regarding NSAID's, MTUS page 22 supports it for chronic low back pain, at least for short-term relief. It is also supported for other chronic pain conditions. MTUS page 60 also states, "A record of pain and function with the medication should be recorded," when medications are used for chronic pain. In this case, there is no documentation of the patient's pain level with or without medication. Furthermore, no documented functional improvement has been provided. The current request does not satisfy the MTUS guidelines as outlined on page 60. The request is not medically necessary.

Retro Ultram 50mg Qty 180: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioid Page(s): 78.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96.

Decision rationale: The patient presents with pain affecting the low back. The current request is for Retro Ultram 50mg Qty 180. The requesting treating physician report does not provide any rationale for the current request. MTUS pages 88 and 89 states "document pain and functional improvement and compare to baseline. Satisfactory response to treatment may be indicated by

the patient's decreased pain, increased level of function, or improved quality of life. Information from family members or other caregivers should be considered in determining the patient's response to treatment. Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS also requires documentation of the four A's (analgesia, ADL's, Adverse effects and Adverse behavior). Reports provided show the patient has been taking Ultram since at least 12/9/13 (21). There are no reports provided that address the medications efficacy in treating the patient's symptoms. In this case, no evidence of functional improvement has been documented and there are no records provided that document the patient's pain levels with and without medication usage and none of the required 4 A's are addressed. The MTUS guidelines require much more thorough documentation to recommend continued opioid usage. The request is not medically necessary.

Retro Flexeril 7.5mg Qty 270: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril) Page(s): 41-42.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63.

Decision rationale: The patient presents with pain affecting the low back. The current request is for Retro Flexeril 7.5mg Qty 270. The treating physician report dated states that Flexeril was prescribed for the patients muscle spasms. MTUS guidelines for muscle relaxants state the following: "Recommended for a short course of therapy. Limited, mixed-evidence does not allow for a recommendation for chronic use." MTUS guidelines for muscle relaxants for pain page 63 states the following: "Recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP." MTUS does not recommend more than 2-3 weeks for use of this medication. Reports provided indicate that the patient has been taking Flexeril since at least 12/9/13 (21). In this case, the use of the medication is outside the 2-3 weeks recommended by MTUS. The request is not medically necessary.