

Case Number:	CM15-0174317		
Date Assigned:	09/16/2015	Date of Injury:	07/11/1997
Decision Date:	11/06/2015	UR Denial Date:	08/27/2015
Priority:	Standard	Application Received:	09/04/2015

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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 49 year old male who sustained an industrial injury on July 11, 1997. A secondary treating recent follow up visit dated August 14, 2015 reported previous treatment modality to include: activity modification, medications, physical therapy, injections, H-wave therapy, home exercises. Current medications regimen consisted of Narcosoft, Norco 10mg 325mg; Tramadol ER; Gabapentin; Flurbiprofen topical cream, Theramine, Sentra PM and AM. The following diagnoses were applied: lumbar region failed back surgery; lumbar radiculopathy; spasm of muscle; constipation; depression; insomnia; anxiety, dissociative and somatoform disorders, and gastritis. An initial pain management evaluation dated March 17, 2015 reported current medication regimen consisted of Flexeril, Omeprazole, Promolaxin, Ambien and Terazosin. There is subjective complaint of constant low back pain radiating to the bilateral hips and buttocks. The following medications were prescribed this visit: Norco 10mg 325mg, Gabapentin, Ambien, Ibuprofen, Neurontin, and stool softener. Previous treatment to include: activity modification, medications, injections, physical therapy, H-wave therapy, exercises and stretching.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 5/325mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids (Classification), Opioids, California Controlled Substance Utilization Review and Evaluation System (CURES) [DWC], Opioids, criteria for use, Opioids for chronic pain.

Decision rationale: Regarding the request for Norco (hydrocodone/acetaminophen), Chronic Pain Medical Treatment Guidelines state that Norco is an opiate pain medication. Due to high abuse potential, close follow-up is recommended with documentation of analgesic effect, objective functional improvement, side effects, and discussion regarding any aberrant use. Guidelines further specify for discontinuation of opioids if there is no documentation of improved function and pain. Within the documentation available for review, there is indication that the medication is improving the patient's pain from 8/10 to 5-6/10. However, there is no documentation of specific functional gain, and no documentation regarding side effects. Furthermore, the request is for a prescription with 3 refills, and the guidelines recommend ongoing use of medication only with documented reduction in pain and functional improvement. As such, the utilization review decision of weaning the medication is upheld. In light of the above issues, the currently requested Norco (hydrocodone/acetaminophen) is not medically necessary.

Tramadol ER 150mg #60 with 3 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids (Classification), Opioids, California Controlled Substance Utilization Review and Evaluation System (CURES) [DWC], Opioids, criteria for use, Opioids for chronic pain.

Decision rationale: Regarding the request for Ultram (tramadol), Chronic Pain Medical Treatment Guidelines state that Ultram is an opiate pain medication. Due to high abuse potential, close follow-up is recommended with documentation of analgesic effect, objective functional improvement, side effects, and discussion regarding any aberrant use. Guidelines go on to recommend discontinuing opioids if there is no documentation of improved function and pain. Within the documentation available for review, there is indication that the medication is improving the patient's pain from 8/10 to 5-6/10. However, there is no documentation of specific functional gain, and no documentation regarding side effects. Furthermore, the request is for a prescription with 3 refills, and the guidelines recommend ongoing use of medication only with documented reduction in pain and functional improvement. As such, the currently requested Ultram (tramadol) is not medically necessary.

Gabapentin 600mg #90 with 3 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antiepilepsy drugs (AEDs).

Decision rationale: Regarding request for gabapentin, Chronic Pain Medical Treatment Guidelines state that antiepilepsy drugs are recommended for neuropathic pain. They go on to state that a good outcome is defined as 50% reduction in pain and a moderate response is defined as 30% reduction in pain. Guidelines go on to state that after initiation of treatment, there should be documentation of pain relief and improvement in function as well as documentation of side effects incurred with use. The continued use of AEDs depends on improved outcomes versus tolerability of adverse effects. Within the documentation available for review, there is indication that the medication is reducing his pain and allowing him to function. However, there is no discussion regarding side effects from this medication. Furthermore, the request is for a prescription with 3 refills, and the guidelines recommend ongoing use of medication only with documented reduction in pain and functional improvement. Unfortunately, there is no provision to modify the current request. As such, the current request is not medically necessary.

Narcosoft capsule #60 with 3 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation <https://enovachem.us.com/product/narcosoft/>.

Decision rationale: The CA MTUS, ODG, or ACOEM do not address narcosoft. Per the product website, Narcosoft is a Medical Nutritional Supplement containing of a blend of soluble fibers and natural laxatives that may help to relieve symptoms of constipation. This includes a proprietary blend of various laxatives. The suggested use of this product is "as a dietary supplement, take two (2) capsules daily with 10 ounces of water, juice, or beverage of choice. Do not exceed four (4) capsules daily." Within the submitted documentation, it is not clear why this anti-constipation agent was utilized as opposed to well known laxatives such as senna, colace, docusate or psyllium. Because this is not a product acknowledged by guidelines and with limited peer reviewed evidence to support its efficacy, it is not medically necessary.

Unknown prescription of Terocin patches: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: Regarding the request for Terocin, Terocin is a combination of methyl salicylate, menthol, lidocaine and capsaicin. Chronic Pain Medical Treatment Guidelines state that any compounded product that contains at least one drug or drug class that is not recommended is not recommended. Regarding the use of topical lidocaine, guidelines state that it is recommended for localized peripheral pain after there is evidence of a trial of first-line therapy. Within the documentation available for review, there is no evidence of failure of first-line therapy as recommended by guidelines prior to the initiation of topical lidocaine. Furthermore, only topical lidocaine in patch form as Lidoderm is recommended per CPMTG, and thus this component is not recommended. Therefore, the currently requested Terocin is not medically necessary.

Flurbiprofen cream 20% #2 with 3 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: Regarding the request for topical flurbiprofen, guidelines state that topical NSAIDs are recommended for short-term use. Oral NSAIDs contain significantly more guideline support, provided there are no contraindications to the use of oral NSAIDs. Within the documentation available for review, there is no documentation that the patient would be unable to tolerate oral NSAIDs, which would be preferred, or that the topical flurbiprofen is for short-term use, as recommended by guidelines. In the absence of clarity regarding those issues, the currently requested topical flurbiprofen is not medically necessary.