

Case Number:	CM15-0178751		
Date Assigned:	09/21/2015	Date of Injury:	03/23/2010
Decision Date:	11/13/2015	UR Denial Date:	08/13/2015
Priority:	Standard	Application Received:	09/11/2015

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: New York, California
 Certification(s)/Specialty: Emergency Medicine

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 sustained an industrial injury on March 23, 2010. Primary treating office visit dated May 26, 2015 reported chief subjective complaint of severe low back pain; bilateral leg pain, and thoracic pain. He is with continued pain in the low back that radiates down his legs and into his feet. Pain medications "help him to continue his daily activities and increase his function." The following diagnoses were applied to this visit: herniated nucleus pulposus with severe left sided dural compression; multi-level degenerative disc disease; facet hypertrophy; low back strain with radiculopathy, and history of low strain requiring 6 months of therapy before deemed permanent and stationary with full recovery. The plan of care is with recommendation for refilling Norco, Flexeril, Colace, and Motrin; continue with home exercise program. Primary follow up in March 24, 2015 reported chief subjective complaint of severe low back pain; bilateral leg pain, and thoracic pain. The plan of care is with recommendation to continue medications with refills; home exercises; Terocin cream; recommendation for acupuncture therapy and follow up with pain management. Primary follow up dated January 21, 2015 reported unchanged subjective complaint; treating diagnoses; and plan of care.

IMR ISSUES, DECISIONS AND RATIONALES

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

Docqlace 100mg x 1 month supply: 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: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use, Opioids for chronic pain.

Decision rationale: CAMTUS chronic pain guidelines recommend prophylactic treatment of constipation when prescribing opiates for analgesia. The IW has been on opiate medications for a minimum of 6-months and has been taking stool softeners during this time. There is no documentation in the record relating the IW bowel habits. Ongoing prescribing of Docqlace in the setting of narcotics is appropriate. However, opiate prescriptions should be closely monitored with ongoing assessments of functional improvements related to prescribed medications. As such, the ongoing use of a Docqlace is dependent upon the ongoing use of opiates. Additionally, the request does not include dosing or frequency of this medication. The request is for a "month supply," but without the frequency this is an unknown quantity. The request for Docqlace is not medically necessary.

Ibuprofen 800mg x 1 month supply: 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): NSAIDs (non-steroidal anti-inflammatory drugs).

Decision rationale: According to CA MTUS chronic pain guidelines, non-steroidal anti-inflammatory agents are recommended as an option for short-term symptomatic relief for the treatment of chronic low back pain. Further recommendations are for the lowest dose for a minimal duration of time. The IW has been on this medication for a minimum of 6 months. Specific recommendations for ibuprofen (Motrin) state sufficient clinical improvement should be observed to offset potential risk of treatment with the increase dose. The documentation does not support improvement of symptoms with NSAIDs currently prescribed. Additionally, the request does not include dosing or frequency of this medication. The request is for a "month supply," but without the frequency this is an unknown quantity. The request is medically not necessary.

Hydrocodone/APAP 10/325mg #180: 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 for chronic pain, Opioids, long-term assessment, Opioids, specific drug list.

Decision rationale: CA MTUS, chronic pain guidelines, offer very specific guidelines for the ongoing use of narcotic pain medication to treat chronic pain, these recommendations state that the lowest possible dose be used as well as ongoing review and documentation of pain relief, functional status, appropriate medication use and its side effects. It also recommends that providers of opiate medication document the injured worker's response to pain medication including the duration of symptomatic relief, functional improvements, and the level of pain relief with the medications. The included documentation fails to include the above recommended documentation. The documentation does not discuss specific response to prescribed medication.

The IW has been taking hydrocodone for a minimum of 6 months without evidence of functional improvement. In addition, the request does not include dosing frequency or duration. The request for opiate analgesia is not medically necessary.

Cyclobenzaprine 10mg x 1 month supply: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: According to CA MTUS, cyclobenzaprine is recommended as an option for short course of therapy. Effect is noted to be modest and is greatest in the first 4 days of treatment. The IW has been receiving this prescription for a minimum of 6 months according to submitted records. This greatly exceeds the recommended timeframe of treatment. The IW's response to this medication is not discussed in the documentation. The request is for a "month supply," but without the frequency, this is an unknown quantity. The request is not medically necessary.