

Case Number:	CM15-0038341		
Date Assigned:	03/09/2015	Date of Injury:	11/06/2007
Decision Date:	06/09/2015	UR Denial Date:	01/30/2015
Priority:	Standard	Application Received:	03/02/2015

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

Certification(s)/Specialty: Pediatrics, Internal 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 45 year old male who sustained an industrial injury on 11/6/07. He currently complains of constant, dull achy throbbing low back pain with radiation to both lower extremities with associated weakness, numbness and headaches. Medications are Fioricet, clonazepam, escitalopram, Seroquel XR, bupropion, omeprazole, cyclobenzaprine, Anaprox, Lyrica, docusate, Terocin. Diagnoses include post laminectomy lumbar spine; lumbar radiculopathy; herniated nucleus propulsus L5-S1, status post discectomy; lumbar herniated nucleus propulsus with myelopathy. Treatments to date include lumbar epidural steroid injections. Diagnostics include MRI lumbar spine 2/29/12, 8/5/09, 8/18/08, 12/26/07; lumbar spine x-ray, all demonstrated abnormal findings. In the progress note dated 1/21/15 the treating provider indicated that the medications requested are indicated for functional restoration and to help with pain control. The Terocin helps improve function and control pain; Anaprox is helping with pain control and inflammation; cyclobenzaprine in this injured worker is for functional restoration and pain control and spasms; omeprazole is to protect against gastrointestinal events and Lyrica was also prescribed.

IMR ISSUES, DECISIONS AND RATIONALES

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

Naproxen (Anaprox) #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAID's Page(s): 67-68.

Decision rationale: According to the MTUS and ODG guidelines NSAID's are recommended for osteoarthritis, chronic back pain and acute exacerbations of back pain. There is no evidence that the IW had an adequate trial of acetaminophen. This request is not medically necessary and appropriate.

Omeprazole 20mg (Prilosec) #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 rationale: According to MTUS guidelines it is necessary to determine if the patient is at risk for gastrointestinal events. Risk factors are: (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). A history of ulcer complications is the most important predictor of future ulcer complications associated with NSAID use. There was no notation of GI symptoms or a history of risk factors. This request is not medically necessary and appropriate.

Cyclobenzaprine (Flexeril) 7 #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63-65.

Decision rationale: MTUS recommends non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP. It is noted that in most LBP cases, they show no benefit beyond NSAIDs in pain and overall improvement. Also there is no additional benefit shown in combination with NSAIDs. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. The IW is noted to be on an NSAID and that the muscle relaxant is to be taken twice daily regularly. The request is not medically necessary and appropriate.

Lyrica 75mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs) Page(s): 15-19.

Decision rationale: MTUS guidelines state that antiepileptic drugs are recommended for neuropathic pain. A "good" response to the use of AEDs has been defined as a 50% reduction in pain and a "moderate" response as a 30% reduction. The patient should be asked at each visit as to whether there has been a change in pain or function. It is noted that there is no EMG/NCV in the case file to document neuropathy in the IW. There was no documentation of objective functional benefit with prior use of this medication. The request is not medically necessary and appropriate.

Terocin #30: 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 guidelines state that lidocaine is recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy. The documentation in the case file does not indicate that the IW tried any other medications without success. Even though menthol is approved for topical use this cannot be approved due to other components not being medically necessary. This request is not medically necessary.