

Case Number:	CM14-0130410		
Date Assigned:	09/23/2014	Date of Injury:	10/23/2009
Decision Date:	11/17/2014	UR Denial Date:	07/18/2014
Priority:	Standard	Application Received:	08/15/2014

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 and Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Texas. 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 34-year-old female who reported an injury on 10/23/2009. The mechanism of injury was not submitted for this review. The injured worker treatment history included medications, MRI studies, psychotherapy sessions, neurological evaluations and treatment, ultrasound, and topical medications. The medical records were reviewed. The injured worker was evaluated on 08/25/2014 and was documented that the injured worker she is able to bring her pain down to a 2/10 to a 3/10 with her medications, whereas, without her medications, her pain would be a 7/10 to 8/10 and higher. She stated that her medications takes affect within half an hour and lasts for usually about 4 hours. She was able to do 45 minutes of light house work as well as self-care activities of daily living with her medications as previously mentioned. There were no aberrant behaviors. The injured worker denied any adverse reactions. The injured worker will be going to Oregon for the next few months due to a medical issue regarding her family members. Findings revealed deep tendon reflexes are equal and symmetrical in the bilateral lower extremities. There were no upper tract findings. There was extremity edema noted on gross observation. The rest of the examination was unchanged. Medications included Norco 10/325 mg, Gabapentin 400 mg, Phenergan 25 mg, Prilosec 25 mg, Bio freeze, Xanax 0.5 mg, Robaxin, Percocet 5/325 mg, Naprosyn and Cymbalta 50 mg. Diagnoses included low back pain with L5-S1 with a 5 mm disc extrusion posteriorly to the left with an annular disc tear at L4-5, with 2 mm disc protrusion posteriorly to the right L3-4 with a 1 mm to 2 mm disc bulge posteriorly to the right; lumbar radiculitis; left knee pain) secondary to straining injury; left elbow strain, resolved. The Request for Authorization dated 09/03/2014 was for Bio freeze gel, Neurontin, Robaxin, Naprosyn, Norco, Prilosec, Xanax, Phenergan, Percocet, and Cymbalta.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective: Robaxin 750mg #60, 2 months supply (DOS: 6/24/14): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Non-Sedating Muscle Relaxants.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants, Robaxin Page(s): 63, 65.

Decision rationale: The requested service is not medically necessary. According to the California MTUS Chronic Pain Medical Guideline recommends non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic low back pain. Muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in most low back pain cases, they show no benefit beyond NSAIDs in pain and overall improvement. The mechanism of action is unknown, but appears to be related to central nervous system depressant effects with related sedative properties. This drug was approved by the FDA in 1957. The documentation submitted lacked evidence of outcome measurements of conservative care such as prior physical therapy sessions and medication pain management. In addition, the request lacked frequency and duration of the medication. The request for Retrospective Robaxin 750mg #60, 2 months' supply dispensed 6/24/14 is not medically necessary.

Retrospective: Prilosec 20mg #60, 2 month supply (DOS: 6/24/14): Upheld

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

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

Decision rationale: The request is not medically necessary. Prilosec is recommended for patients taking NSAIDs who are at risk of gastrointestinal events. The documentation submitted did not indicate the injured worker having gastrointestinal events however, it was not clear if it was from medications. The provider failed to indicate the frequency or dosage medication on the request that was submitted. In addition, the provider failed to indicate long term functional goals or medication pain management for the injured worker. Given the above, the retrospective request for Prilosec 20mg #60, 2 month supply dispensed 6/24/14 is not medically necessary.

Retrospective: Biofreeze x 2 tubes, 2 month supply (DOS: 6/24/14): Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Bio Freeze

Decision rationale: The request for Bio freeze is not medically necessary. The Official Disability Guidelines recommend Bio freeze as an optional form of cryotherapy for acute pain. Bio freeze is a non-prescription topical cooling agent with the active ingredient of menthol that takes the place of ice packs. Whereas ice packs only worked for a limited period of time, Bio freeze can last much longer before reapplication. A recent study concluded that Bio freeze on acute low back pain resulted in significant pain reduction. The included medical documents lack evidence a complete and accurate pain assessment and the efficacy of the medication. Also, the guidelines recommend Bio freeze in the acute phase of pain, the worker was injured in 2009 which would indicate a chronic issue as opposed to acute. The request for Retrospective: Biofreeze x 2 tubes, 2 month supply dispensed 6/24/14 is not medically necessary.

Retrospective: Norco 10mg max of 6 a day #180, 2 month supply (DOS: 6/24/14): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use Page(s): 78.

Decision rationale: The requested Norco 10 mg is not medically necessary. The California Medical Treatment Utilization Schedule (MTUS) Schedule (MTUS) guidelines state that criteria for use for ongoing- management of opioids include ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. There was lack of documentation of long-term functional improvement for the injured worker. The provider failed to include urine drug screen to verify opiate compliance. As such, the request for Retrospective: Norco 10mg max of 6 a day #180, 2 month supply dispensed 6/24/14 is not medically necessary.

Retrospective: Xanax 0.5mg #60, 2 month supply (DOS: 6/24/14): Upheld

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

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

Decision rationale: The requested is not medically necessary. The California MTUS Chronic Pain Medical Guidelines does not recommend Benzodiazepines for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. Their range of action includes sedative/hypnotic, anxiolytic, anticonvulsant, and muscle relaxant. Chronic benzodiazepines are the treatment of choice in very few conditions. Tolerance to hypnotic effects develops rapidly. Tolerance to anxiolytic effects occurs within months and long-term use may actually increase anxiety. A more appropriate treatment for anxiety disorder

is an antidepressant. Tolerance to anticonvulsant and muscle relaxant effects occurs within weeks. The documents submitted for review was unclear of how long the injured worker has been using Benzodiazepines. Furthermore, the request lacked frequency and duration of the medication. As such, the request for Retrospective: Xanax 0.5mg #60, 2 month supply dispensed 6/24/14 is not medically necessary.

Retrospective: Percocet 5mg as needed #5: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use Page(s): 78.

Decision rationale: The requested Percocet 5 mg is not medically necessary. The California Medical Treatment Utilization Schedule (MTUS) Schedule (MTUS) guidelines state that criteria for use for ongoing- management of opioids include ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The provider failed to include a urine drug screen to verify opiate compliance. Additionally, the request failed to include frequency and duration of medication. As such, the request for Percocet 5mg as needed #5 is not medically necessary.

Retrospective: Phenergan 25mg as needed #50: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), Antiemetic's (for opioid nausea)

Decision rationale: The request for Phenergan 25 mg as needed # 50 is not medically necessary. The Official Disability Guidelines (ODG) does not recommend Phenergan/Zofran for nausea and vomiting secondary to chronic opioid use. Nausea and vomiting is common with the use of opioids. Side effects tend to diminish over days to weeks of continued exposure. Studies of opioid adverse effects including nausea and vomiting are limited to short-term duration (less than four weeks) and have limited application to long-term use. If nausea and vomiting remains prolonged, other etiologies of these symptoms should be evaluated for. The differential diagnosis includes gastro paresis (primarily due to diabetes). Current research for treatment of nausea and vomiting as related to opioid use primarily addresses the use of antiemetics in patients with cancer pain or those utilizing opioids for acute/postoperative therapy. Recommendations based on these studies cannot be extrapolated to chronic non-malignant pain patients. There is no high-quality literature to support any one treatment for opioid-induced nausea in chronic non-malignant pain patients. The documents submitted does not warrant the need for the injured worker need Phenergan. Additionally, the documentation provided does not indicate the injured

worker having a diagnoses of cancer or acute/postoperative therapy. Given the above, the request is not medically necessary.

Requesting 3-6 month authorization on all medications: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 77.

Decision rationale: The request for 3-6 month authorization on all medications is not medically necessary. According to MTUS/ACOEM functional improvement means either a clinically significant improvement in activities of daily living or reduction in work restrictions is measured during the history and physical examination performed and documented as part of the evaluation and management visit billed under the Official Medical Fee Schedule (OMFS) pursuant to sections 97.89.10-9789.111; the reduction that dependence of continued medical treatment. As such, the request for requesting 3-6 month authorization on all medications is not medically necessary.