

Case Number:	CM13-0020427		
Date Assigned:	10/11/2013	Date of Injury:	05/12/2004
Decision Date:	02/18/2014	UR Denial Date:	08/22/2013
Priority:	Standard	Application Received:	09/05/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Pain Management and is licensed to practice in California, Maryland, Florida, and the District of California. 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 physician 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:

According to medical record reviewed, the claimant is a 60 year old female with a date of injury of 5/12/2004. She stated that on May 12, 2004, while changing linen on a bed, she tripped on a shoe that was lying on the floor, which - caused her to fall forward, and she landed on both knees. She broke her fall with her hands by having her arms fully extended. As a result of the fall, she experienced immediate severe pain in her right wrist and thumb, as well as her right knee with associated swelling. She promptly reported the injury to her employer. She was then taken to [REDACTED] where she was examined and x-rays were obtained. She was diagnosed with a possible fracture of the right wrist. She was administered injection for pain. She was also provided a splint to wear. The following day, she was referred to [REDACTED]. She was seen in the emergency room where she was. Examined and x-rays were obtained. She was administered an injection for pain and her arm was placed in a cast. She was also provided with prescription medication and placed on temporary total disability. On May 21, 2004, she had a follow up visit at [REDACTED]. The cast was removed and replaced. She was diagnosed at that time with gamekeeper's thumb. She returned on July 22, 2004 for further follow-up at [REDACTED]. She was again examined. The cast was removed and she provided with a wrist brace. On August 28, 2004, she was released to return to work at her usual and customary duties as per evaluation by [REDACTED] on 7/1/2013; the patient was being treated for chronic cervical spine pain. At the time of this evaluation, the patient complained of constant nagging and aching, 9/10 neck pain with radiation into the bilateral upper extremities with numbness in the fingers. Objective findings at the time of this evaluation included tenderness over C5-C7 nerve roots and facets, positive axial head compression, and decreased cervical range of motion. The patient has been diagnosed with cervical radiculopathy, facet arthropathy, and musculoligamentous sprain/strain. The most recent

appeal letter from the treating physician dated 9/19/2013, states: In her most recent follow-up visit on August 28, 2013, she had complaints of unchanged neck pain and stiffness, as well as unchanged radiating pain to right upper extremity. She described the pain as severe and was unchanged with the procedures under [REDACTED]. Due to the severity of her symptoms she used previously prescribed medication which was Norco. Examination of her cervical spine revealed +2 pain at the right cervical and cervico-thoracic paraspinal] musculature. There was also +1 pain at the level of C2. Allodynia to light touch was noted over right CS, C6 and C7 dermatomes. Active range of motion for the cervical spine was limited in all planes. Shoulder depression test on the right was positive. Vicodin was discontinued and Norco was prescribed. Authorization was requested. She was to return for follow up in six weeks time. At issue is the retrospective request for 60 Vicodin 5/500mg and 30 Prilosec 20mg which was denied for lack of medical necessity.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective medication request for 60 Vicodin 5/500 mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines The Physician Reviewer based his/her decision on Chronic Pain Medical Treatment Guidelines Opioid.

Decision rationale: CA-MTUS (Effective July 18, 2009) page 75 to 76 of 127 sections on opioids: Vicodin® is as short-acting opioids, also known as "normal-release" or "immediate-release" opioids are seen as an effective method in controlling chronic pain. They are indicated for moderate to moderately severe pain, and are often used for intermittent or breakthrough pain. These agents are often combined with other analgesics such as acetaminophen and aspirin. These adjunct agents may limit the upper range of dosing of short acting agents due to their adverse effects. The duration of action is generally 3-4 hours. (Baumann, 2002). The usual dose of 5/500mg is 1 or 2 tablets PO every four to six hours as needed for pain (Max 8 tablets/day). For higher doses of hydrocodone (>5mg/tab) and acetaminophen (>500mg/tab) the recommended dose is usually 1 tablet every four to six hours as needed for pain. Hydrocodone has a recommended maximum dose of 60mg/24 hours. The dose is limited by the dosage of acetaminophen, which should not exceed 4g/24 hours. Opioids should be continued (a) If the patient has returned to work, (b) If the patient has improved functioning and pain. On-Going Management. Of Opioid treatment stipulates: Actions Should Include: Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. 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. The 4 A's for Ongoing Monitoring: Four domains have been proposed as

most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or no adherent) drug-related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. (Passim, 2000) The attending provider stated in the most recent follow-up visit on August 28, 2013, "She had complaints of unchanged neck pain and stiffness, as well as unchanged radiating pain to right upper extremity. She described the pain as severe and was unchanged with the procedures under [REDACTED]. Due to the severity of her symptoms she used previously prescribed medication which was Norco. Examination of her cervical spine revealed +2 pains at the right cervical and cervico-thoracic paraspinal musculature. There wa

30 Prilosec 20 mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines on Chronic Pain Medical Treatment Guidelines NSAID, GI Symptoms 68 and cardiovascular risk factor.

Decision rationale: Prilosec or PPI is recommended with precautions in patients taking NSAID, because of potential development of gastro-intestinal bleeding. According to Chronic Pain Medical Treatment Guidelines page 68 (MTUS -Effective July 18, 2009) clinicians should weight the indications for NSAIDs against both GI and cardiovascular risk factors. Determine if the patient is at risk for gastrointestinal events: (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). The patient does not fall into any of these categories; hence the request for Prilosec 20mg is not medically necessary. In the appeal letter from the treating physician dated 9/19/2013, he stated that "In conjunction with the use of oral pain killers, a prophylaxis treatment regimen to prevent further complications and affectations was prescribed, thus the prescription for Prilosec. It was prescribed not because the patient has a gastrointestinal pathology, but rather as a preemptive measure. This is supported by the California MTUS which states that, PPI may be required for those patients with GI risk factors. Prilosec, which is a gastro protectant drug, is a vital component of the patient's pharmacological therapy because this drug will effectively counteract the gastric side effects of her oral anti-inflammatory pain medications. To further substantiate my request, the combination of non-steroidal anti-inflammatory drugs and proton pump inhibitors such as Prilosec is generally accepted by the Official Disability Guidelines Treatment in Workers' Comp and quoted that this could be afforded to patient at intermediate risk for gastrointestinal events and with no cardiovascular disease: A non-selective NSAID with either a PPI (Proton Pump Inhibitor). Therefore, the patient will not be discouraged to take her pain medications because its systemic side effects would be less. Pain relief and comfort could be provided to the patient and at the same time further complications would be prevented with these medications." However, in

the recent medication list, there was no NSAID therapy included. Therefore the request for 30 Prilosec 20 mg is not medically necessary.