

Case Number:	CM13-0020862		
Date Assigned:	10/11/2013	Date of Injury:	04/13/2010
Decision Date:	01/09/2014	UR Denial Date:	08/28/2013
Priority:	Standard	Application Received:	09/06/2013

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 physical medicine & rehabilitation, has a subspecialty in sports medicine, and is licensed to practice in New York and 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 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.

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 patient is a 49-year-old who reported an injury on 04/13/2010. The patient is currently diagnosed with cervical myoligamentous injury with bilateral upper extremity radicular symptoms, lumbar myoligamentous injury with bilateral lower extremity radicular symptoms, post-traumatic avascular-type headaches, medication-induced gastritis, history of gastric bypass, history of left shoulder arthroscopy, left knee arthroscopy, history of right knee arthroscopy, history of bilateral carpal tunnel releases, and right shoulder myoligamentous injury. The patient was recently evaluated by [REDACTED] on 09/13/2013. The patient continued to report lower back pain with radiation to bilateral lower extremities rating an 8/10. The patient also complains of progressively worsening neck pain and right shoulder pain. Physical examination revealed decreased range of motion of the cervical spine, 2+ deep tendon reflexes, 5/5 motor strength of bilateral upper extremities, diminished grip strength on the left, decreased sensation at the C5-6 distribution, tenderness to palpation of bilateral lumbar musculature, trigger points, decreased range of motion of the lumbar spine with muscle guarding, diminished strength of the left lower extremity, decreased sensation along the L5-S1 distribution, positive straight leg raising, and atrophy in the left lower extremity. Treatment recommendations included continuation of current medications and posterior lumbar interbody fusion at L4-5 and L5-S1.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325mg #180: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines, a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Baseline pain and functional assessments should be made. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. As per the clinical notes submitted, the patient has utilized this medication since at least 05/22/2013. The patient continued to report 8/10 pain to multiple areas despite the ongoing use of this medication. There was no documentation of objective functional improvement or a decrease in pain level. Satisfactory response to treatment has not been indicated. The ongoing use of this medication cannot be determined as medically appropriate. A previous modified certification was issued on 08/28/2013 with recommendations to initiate a weaning process of this medication. The request for Norco 10/325mg #180 is not medically necessary or appropriate.

Anaprox DS 550mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67-72.

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines, NSAIDs (non-steroidal anti-inflammatory drugs) are recommended for osteoarthritis, at the lowest dose for the shortest period in patients with moderate to severe pain. Acetaminophen may be considered for initial therapy for patients with mild to moderate pain, and in particular, for those with gastrointestinal, cardiovascular, or renovascular risk factors. There is no evidence to recommend 1 drug in this class over another based on efficacy. As per the clinical notes submitted, the patient has utilized this medication for at least 1 year. Despite the ongoing use of this medication, the patient continues to report high levels of pain to multiple areas of the body. Additionally, the patient maintains a diagnosis of medication-induced gastritis and history of gastric bypass. As guidelines do not recommend NSAID therapy in patients with gastrointestinal risk factors, nor do they recommend long term use of NSAID medications, the current request cannot be determined as medically appropriate. The request for Anaprox DS 550mg #60 is not medically necessary or appropriate.

Prilosec 20mg #60: Upheld

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

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

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines, proton pump inhibitors are recommended for patients at intermediate or high risk for gastrointestinal events. Patients with no risk factor and no cardiovascular disease do not require a proton pump inhibitor. As per the clinical notes submitted, the patient does maintain a diagnosis of medication-induced gastritis and history of a gastric bypass. The patient has utilized this medication for at least one year. However, there is no evidence of a failure to respond to first line over the counter treatment prior to the initiation of a prescription product. There is also no subjective or objective evidence of gastrointestinal events or complaints. The request for Prilosec 20mg #60 is not medically necessary or appropriate.

FexMid 7.5mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63-66.

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines, muscle relaxants are recommended as a non-sedating second line option for short term treatment of acute exacerbations in patients with chronic low back pain. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. Cyclobenzaprine is recommended for a short course of therapy and is not recommended to be used for longer than 2 to 3 weeks. As per the clinical notes submitted, the patient has utilized this medication for at least one year. Despite the ongoing use of this medication, the patient continues to report high levels of pain to multiple areas of the body. The patient continues to demonstrate tenderness to palpation, numerous trigger points, and muscle rigidity of the cervical and lumbar spine, despite the ongoing use of a muscle relaxant. Satisfactory response to treatment has not been indicated. The request for FexMid 7.5mg #60 is not medically necessary or appropriate.