

<b>Case Number:</b>	CM13-0036949		
<b>Date Assigned:</b>	12/13/2013	<b>Date of Injury:</b>	08/31/2010
<b>Decision Date:</b>	01/30/2014	<b>UR Denial Date:</b>	09/23/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/22/2013

### 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 and Rehabilitation and is licensed to practice in 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:

This 40 year-old male sustained a cumulative trauma injury to the low back on 8/31/10 while employed by [REDACTED]. Requests under consideration include Pantoprazole tab 20mg #30, Venlafaxine (Effexor) 75 / 37.5mg #30 dispensed x one refill, and Hydrocodone (Norco) 2.5 / 325 #90. QME report from [REDACTED] dated 7/2/13 had diagnoses of cervical spondylosis without cervical restrictions/instability or radiculomyelopathy; Right T8-T9 resolving protrusion; T9-T10 radiculopathy without hernia or lipoma; L4-S1 disc protrusion without radiculopathy or instability; and Sleep disorder. Future medical care included non-addicting analgesics, occasional short courses of NSAIDs, no invasive procedure such as SCS, Rhizotomy, ESIs or surgery; Does not require surgical consultation at spine clinic. Report dated 8/15/13 from [REDACTED] noted the patient with chronic low back pain. Exam findings included pain on lumbar flexion, spasm over left hip and lumbar paraspinals, positive SLR, antalgic gait on left. Diagnoses included thoracic sprain/strain; myelopathy thoracic; lumbar strain/sprain; discogenic pain; sacroiliitis; lumbosacral radiculopathy; chronic pain syndrome. Treatment included the above medication requests which were non-certified on 9/23/13, citing guidelines criteria and lack of medical necessity.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Pantoprazole tab 20mg #30:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms and Cardiovascular risk Page(s): 68-69.

**Decision rationale:** This 40 year-old male sustained a cumulative trauma injury to the low back on 8/31/10 while employed by [REDACTED]. Requests under consideration include Pantoprazole tab 20mg #30, Venlafaxine (Effexor) 75 / 37.5mg #30 dispensed x one refill, and Hydrocodone (Norco) 2.5 / 325 #90. QME report from [REDACTED] dated 7/2/13 had future medical care included non-addicting analgesics, occasional short courses of NSAIDs, no invasive procedure such as SCS, Rhizotomy, ESIs or surgery; Does not require surgical consultation at spine clinic. Report dated 8/15/13 from [REDACTED] noted the patient with chronic low back pain. Exam findings included pain on lumbar flexion, spasm over left hip and lumbar paraspinals, positive SLR, antalgic gait on left. Diagnoses included thoracic sprain/strain; myelopathy thoracic; lumbar strain/sprain; discogenic pain; sacroiliitis; lumbosacral radiculopathy; chronic pain syndrome. Pantoprazole (Protonix) medication is for treatment of the problems associated with erosive esophagitis from GERD, or in patients with hypersecretion diseases. Per MTUS Chronic Pain Treatment Guidelines, the patient does not meet criteria for this medication, reserved for patients with history of prior GI bleeding, the elderly (over 65 years), diabetics, and chronic cigarette smokers. Submitted reports have not described or provided any GI diagnosis that meets the criteria to indicate medical treatment. Review of the records show no documentation of any GI diagnosis to warrant treatment. Pantoprazole tab 20mg #30 is not medically necessary and appropriate.

**Venlafaxine (Effexor) 75 / 37.5mg #30 dispensed x one refill:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressant for Chronic Pain Page(s): 13-16.

**Decision rationale:** This 40 year-old male sustained a cumulative trauma injury to the low back on 8/31/10 while employed by [REDACTED]. Requests under consideration include Pantoprazole tab 20mg #30, Venlafaxine (Effexor) 75 / 37.5mg #30 dispensed x one refill, and Hydrocodone (Norco) 2.5 / 325 #90. QME report from [REDACTED] dated 7/2/13 had future medical care included non-addicting analgesics, occasional short courses of NSAIDs, no invasive procedure such as SCS, Rhizotomy, ESIs or surgery; Does not require surgical consultation at spine clinic. Report dated 8/15/13 from [REDACTED] noted the patient with chronic low back pain. Exam findings included pain on lumbar flexion, spasm over left hip and lumbar paraspinals, positive SLR, antalgic gait on left. Diagnoses included thoracic sprain/strain; myelopathy thoracic; lumbar strain/sprain; discogenic pain; sacroiliitis; lumbosacral radiculopathy; chronic pain syndrome. There is no report of psychological issues or diagnosis requiring an anti-depressant. MTUS Medical Treatment Guidelines do not recommend Cymbalta, a Selective Serotonin and Norepinephrine ReUptake Inhibitor (SSRI/SNRIs) without

evidence of failed treatment with first-line tricyclics (TCAs) not evident here. Tolerance may develop and rebound insomnia has been found as for this patient who has sleeping complaints. Cymbalta may be an option in patients with coexisting diagnosis of major depression that is not the case here. There is no documented failed trial with first-line TCAs or any diagnosis of depression. The patient has received treatment with Effexor; however, there is no documented functional improvement derived from treatment already rendered. The Venlafaxine (Effexor) 75 / 37.5mg #30 dispensed x one refill is not medically necessary and appropriate.

**Hydrocodone (Norco) 2.5 / 325 #90:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 79-80.

**Decision rationale:** This 40 year-old male sustained a cumulative trauma injury to the low back on 8/31/10 while employed by [REDACTED]. Requests under consideration include Pantoprazole tab 20mg #30, Venlafaxine (Effexor) 75 / 37.5mg #30 dispensed x one refill, and Hydrocodone (Norco) 2.5 / 325 #90. QME report from [REDACTED] dated 7/2/13 had future medical care included non-addicting analgesics, occasional short courses of NSAIDs, no invasive procedure such as SCS, Rhizotomy, ESIs or surgery; Does not require surgical consultation at spine clinic. Report dated 8/15/13 from [REDACTED] noted the patient with chronic low back pain. Exam findings included pain on lumbar flexion, spasm over left hip and lumbar paraspinals, positive SLR, antalgic gait on left. Diagnoses included thoracic sprain/strain; myelopathy thoracic; lumbar strain/sprain; discogenic pain; sacroiliitis; lumbosacral radiculopathy; chronic pain syndrome. Per the MTUS Guidelines cited, opioid use in the setting of chronic, non-malignant, or neuropathic pain is controversial. Patients on opioids should be routinely monitored for signs of impairment and use of opioids in patients with chronic pain should be reserved for those with improved functional outcomes attributable to their use, in the context of an overall approach to pain management that also includes non-opioid analgesics, adjuvant therapies, psychological support, and active treatments (e.g., exercise). Submitted documents show no evidence that the treating physician is prescribing opioids in accordance to change in pain relief, functional goals with demonstrated improvement in daily activities, decreased in medical utilization or returned to work status. There is no evidence presented of random drug testing or utilization of pain contract to adequately monitor for narcotic safety, efficacy, and compliance. The MTUS provides requirements of the treating physician to assess and document for functional improvement with treatment intervention and maintenance of function that would otherwise deteriorate if not supported. From the submitted reports, there is no demonstrated evidence of specific functional benefit derived from the continuing use of opioids with pain. Hydrocodone (Norco) 2.5 / 325 #90 is not medically necessary and appropriate.