MAXIMUS Federal Services

Case Number:	CM13-0059095		
Date Assigned:	12/30/2013	Date of Injury:	05/09/1995
Decision Date:	04/18/2014	UR Denial Date:	11/12/2013
Priority:	Standard	Application Received:	11/25/2013

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 Internal Medicine and Pulmonary Diseases 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 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 patient is a 74-year-old female who reported an injury on 05/09/1995. The mechanism of injury was not stated. The patient is currently diagnosed with cervical spine sprain, left upper extremity radiculopathy, status post anterior cervical discectomy and fusion in June 2004, cervicogenic headaches, and reactionary depression with anxiety. The patient was seen by [redacted] on 10/10/2013. The patient reported ongoing 7/10 cervical spine pain with cervicogenic headaches and radiation to the left upper extremity. The patient has been previously treated with epidural steroid injections, trigger point injections, and physical therapy. The patient currently utilizes a TENS unit. Physical examination revealed tenderness to palpation, increased muscle rigidity, decreased range of motion, and decreased sensation. Treatment recommendations included continuation of current medications and outpatient physical therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

ANAPROX DS 550MG #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation ODG

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

Decision rationale: The California MTUS Guidelines state that nonsteroidal anti-inflammatory drugs (NSAIDs) are recommended for osteoarthritis at the lowest dose for the shortest period in patients with moderate to severe pain. For acute exacerbations of chronic pain, NSAIDs are recommended as a second-line treatment after acetaminophen. There is no evidence of long-term effectiveness for pain or function. As per the documentation submitted, the patient has continuously utilized this medication. Despite ongoing use, the patient continues to report 7/10 pain. There is no documentation of a satisfactory response to treatment. Therefore, Anaprox is not medically necessary or appropriate at this time.

SYNOVACIN 500 MG #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 50.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 50.

Decision rationale: The California MTUS Guidelines state that glucosamine and chondroitin sulfate are recommended as an option, given the low risk, in patients with moderate arthritis pain. As per the documentation submitted, the patient does not maintain a diagnosis of osteoarthritis. Additionally, the patient has continuously utilized this medication. Despite ongoing treatment, the patient continues to report high levels of pain. Satisfactory response to treatment has not been indicated. Therefore, Synovacin is not medically necessary or appropriate at this time.

PRILOSEC 20 MG #120: Upheld

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

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

Decision rationale: The California MTUS Guidelines state that proton pump inhibitors are recommended for patients at intermediate or high risk of gastrointestinal events. Patients with no risk factor and no cardiovascular disease do not require the use of a proton pump inhibitor, even in addition to a nonselective NSAID. As per the documentation submitted, there is no indication of cardiovascular disease or increased risk factors for gastrointestinal events. Therefore, the patient does not currently meet criteria for the requested medication. As such, the Prilosec is not medically necessary or appropriate at this time.

LEXAPRO 5MG #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 13, 16. Decision based on Non-MTUS Citation ODG, Pain

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 107.

Decision rationale: The California MTUS Guidelines state that selective serotonin re-uptake inhibitors (SSRIs) are not recommended as a treatment for chronic pain, but may have a role in treating secondary depression. As per the documentation submitted, the patient does maintain a diagnosis of reactionary depression and anxiety. However, the patient has continuously utilized this medication. There is no documentation of objective functional improvement. Based on the clinical information received, Lexapro is not medically necessary or appropriate at this time.

XANAX 0.25 MG #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 24. Decision based on Non-MTUS Citation ODG, Pain

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

Decision rationale: The California MTUS Guidelines state that benzodiazepines are not recommended for long-term use, because long-term efficacy is unproven and there is a risk of dependence. As per the documentation submitted, the patient does maintain a diagnosis of reactionary depression and anxiety. However, there is no evidence of objective improvement despite ongoing use of this medication. As the guidelines do not recommend long-term use of this medication, the current request cannot be determined as medically appropriate. As such, Xanax is not medically necessary or appropriate at this time.