

Case Number:	CM13-0064233		
Date Assigned:	01/03/2014	Date of Injury:	10/23/2001
Decision Date:	05/20/2014	UR Denial Date:	11/26/2013
Priority:	Standard	Application Received:	12/11/2013

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 Pain Management, 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:

The patient is a 42 year old female who was injured on 10/23/2001. The mechanism of injury is unknown. The patient's medications as of 11/13/2013 include: Norco, Gabapentin, Aspirin, Morphine sulfate, Zanaflex, Sprix, Famotidine, Pennsaid, Restoril, and Xanax. Urine drug screen performed on 11/13/2013 detected positive results for benzodiazepine and Opiates/Morphine. Diagnostic studies reviewed include Cervical MRI dated 07/23/2013 revealed cervical spondylosis, most severe at C6-7 with mild disk bulging eccentric to the left causing mild left-sided foraminal narrowing; loss of normal cervical lordosis due to muscle spasms. EMG/NCS dated 07/05/2007 indicated the EMG study could not rule out the possibility of C5-C6 nerve root irritation on the left. Periodic Report dated 11/13/2013 stated the patient presented with chronic problems including cervical spondylosis without myelopathy, cervical radiculopathy, facet arthropathy, unspecified myalgia and myositis, thoracic or lumbosacral radiculopathy and chronic pain syndrome. She complained of persistent, moderate pain. The pain was located in her upper back, middle back, arms, neck, and head. The patient described the pain as aching, burning, deep and discomforting; with numbness, piercing, throbbing and sharp in nature. The symptoms are aggravated by any activity. She reported the symptoms are relieved by exercise, heat, ice, lying down, injection, massage, pain meds/drugs, physical therapy, and injection. She stated she has to change positions often. She rated her pain as 5/10. The medications prescribed at this visit were Zanaflex, Sprix, Pepcid, Pennsaid, Norco, Morphine Sulfate ER, Gabapentin, and aspirin.

IMR ISSUES, DECISIONS AND RATIONALES

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

PEPCID 20 MG #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines SECTION NSAIDS, GI SYMPTOMS & CARDIOVASCULAR RISK Page(s): 68-69.

Decision rationale: The medical records reviewed do not document any gastrointestinal complaints. The California MTUS guidelines indicate that proton pump inhibitor (PPI) medications such as Omeprazole (Prilosec) may be indicated for patients at risk for gastrointestinal events, which should be determined by the clinician: 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 guidelines recommend GI protection for patients with specific risk factors, however, the medical records do not establish the employee is at significant risk for GI events. Treatment of dyspepsia secondary to NSAID therapy recommendation is to stop the NSAID, switch to a different NSAID, or consider H2-receptor antagonists or a PPI. In absence of documented dyspepsia unresponsive to change in cessation or change of NSAID or PPI, the medical necessity of Pepcid has not been established. In accordance with the California MTUS guidelines, Pepcid is not medically necessary.