

Case Number:	CM13-0064334		
Date Assigned:	01/03/2014	Date of Injury:	05/26/2010
Decision Date:	05/12/2014	UR Denial Date:	11/25/2013
Priority:	Standard	Application Received:	12/11/2013

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 Anesthesiology 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 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:

According to the records made available for review, this is a 43-year-old female with a 5/26/10 date of injury. At the time (7/3/13) of request for authorization for retrospective Omeprazole/PriLOSEC 20mg #60 (DOS 7/03/13), retrospective Meloxicam/Mobic 7.5mg #60 (DOS 7/03/13), retrospective Zolpidem Tartrate/Ambien 10mg #30 (DOS 7/03/13), there is documentation of subjective (increased headaches due to neck pain and bilateral wrist pain with numbness and tingling) and objective (not specified) findings, current diagnoses (chronic musculoligamentous sprain of the cervical spine, right shoulder rotator cuff repair, bilateral upper extremities overuse syndrome, and lateral epicondylitis), and treatment to date (medications (including ongoing treatment with Omeprazole, Meloxicam, and Tramadol since at least 2/16/13)). Regarding retrospective Omeprazole/PriLOSEC 20mg #60 (DOS 7/03/13), there is no documentation of GI disorders (gastric/duodenal ulcers, GERD, erosive esophagitis, or patients utilizing chronic NSAID therapy). Regarding retrospective Meloxicam/Mobic 7.5mg #60 (DOS 7/03/13), there is no documentation of signs and symptoms of osteoarthritis; and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Meloxicam use to date. Regarding retrospective Zolpidem Tartrate/Ambien 10mg #30 (DOS 7/03/13), there is no documentation of insomnia; the intention to treat over a short course (less than two to six weeks); and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Ambien use to date.

IMR ISSUES, DECISIONS AND RATIONALES

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

RETROSPECTIVE OMEPRAZOLE/PRILOSEC 20MG #60 (DOS 7/03/13): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI Symptoms & Cardiovascular Risk.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI Symptoms & Cardiovascular Risk Page(s): 68-69. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), Proton pump inhibitors (PPIs)

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies that risk for gastrointestinal event includes age > 65 years; history of peptic ulcer, GI bleeding or perforation; concurrent use of ASA, corticosteroids, and/or an anticoagulant; and/or high dose/multiple NSAID. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. ODG identifies documentation of risk for gastrointestinal events, preventing gastric ulcers induced by NSAIDs, as criteria necessary to support the medical necessity of Omeprazole. Within the medical information available for review, there is documentation of diagnoses of chronic musculoligamentous sprain of the cervical spine, right shoulder rotator cuff repair, bilateral upper extremities overuse syndrome, and lateral epicondylitis. In addition, there is documentation of ongoing treatment with Omeprazole. However, despite documentation of an associated request for Mobic, there is no documentation of GI disorders (gastric/duodenal ulcers, GERD, erosive esophagitis, or patients utilizing chronic NSAID therapy). Therefore, based on guidelines and a review of the evidence, the request for retrospective Omeprazole/Prilosec 20mg #60 (DOS 7/03/13) is not medically necessary.

RETROSPECTIVE MELOXICAM/MOBIC 7.5MG #60 (DOS 7/03/13): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Meloxicam (Mobic) Page(s): 16.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Meloxicam (Mobic) Page(s): 16.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of signs and symptoms of osteoarthritis as criteria necessary to support the medical necessity of Meloxicam (Mobic). MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of chronic musculoligamentous sprain of the cervical spine, right shoulder rotator cuff repair, bilateral upper extremities overuse syndrome, and lateral epicondylitis. In addition, there is documentation of ongoing treatment with Meloxicam. However, there is no documentation of signs and symptoms of osteoarthritis. In addition, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an

increase in activity tolerance; and/or a reduction in the use of medications as a result of Meloxicam use to date. Therefore, based on guidelines and a review of the evidence, the request for retrospective Meloxicam/Mobic 7.5mg #60 (DOS 7/03/13) is not medically necessary.

RETROSPECTIVE ZOLPIDEM TARTRATE/AMBIEN 10MG #30 (DOS 7/03/13):

Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Zolpidem. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Zolpidem. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

Decision rationale: MTUS does not address this issue. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. ODG identifies Ambien (zolpidem) as a prescription short-acting nonbenzodiazepine hypnotic, which is approved for the short-term (usually two to six weeks) treatment of insomnia. Within the medical information available for review, there is documentation of diagnoses of chronic musculoligamentous sprain of the cervical spine, right shoulder rotator cuff repair, bilateral upper extremities overuse syndrome, and lateral epicondylitis. In addition, there is documentation of ongoing treatment with Ambien. However, there is no documentation of insomnia. In addition, given documentation of records reflecting prescriptions for Zolpidem since at least 2/16/13, there is no documentation of the intention to treat over a short course (less than two to six weeks). Furthermore, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Ambien use to date. Therefore, based on guidelines and a review of the evidence, the request for retrospective Zolpidem Tartrate/Ambien 10mg #30 (DOS 7/03/13) is not medically necessary.