

Case Number:	CM13-0069843		
Date Assigned:	01/03/2014	Date of Injury:	05/08/2012
Decision Date:	05/30/2014	UR Denial Date:	12/18/2013
Priority:	Standard	Application Received:	12/24/2013

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 Physical Medicine and Rehabilitation, has a subspecialty in Pain Management and is licensed to practice in 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 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 injured worker is a 61-year-old female who reported an injury on 05/08/2012 due to cumulative trauma while performing normal job duties. The injured worker ultimately underwent a cervical fusion in 09/2013. The injured worker was managed postoperatively with medications and physical therapy. The injured worker was evaluated on 12/02/2013. Objective findings included good strength and sensation in the bilateral upper extremities with persistent posterior neck pain. The injured worker's medications included Norco 10/325 mg, Flexeril 7.5 mg, and Omeprazole. The injured worker's diagnoses included status post C4 through C6 anterior cervical discectomy and fusion. The injured worker's treatment plan included continuation of medications to provide comfort for the injured worker.

IMR ISSUES, DECISIONS AND RATIONALES

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

ACETAMINOPHEN/HYDROCODONE 325MG/10MG: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS, ON-GOING MANAGEMENT Page(s): 78.

Decision rationale: The requested Acetaminophen/Hydrocodone 325 Mg/10 mg is not medically necessary or appropriate. The Chronic Pain Medical Treatment Guidelines recommends the ongoing use of opioids in the management of chronic pain be supported by documentation of functional benefit, evidence of pain relief, managed side effects, and evidence that the injured worker is monitored for aberrant behavior. The clinical documentation submitted for review does indicate that the injured worker has been on this medication for pain control for an extended duration of time. However, there is no documentation of functional benefit or pain relief resulting from the use of this medication. Additionally, there is no documentation that the injured worker is engaged in an opioid pain contract or is monitored for aberrant behavior with urine drug screens. Additionally, the request as it is submitted does not clearly identify a frequency of treatment. Therefore, the appropriateness of the request itself cannot be determined. As such, the requested acetaminophen/hydrocodone 325 mg/10 mg is not medically necessary or appropriate.

CYCLOBENZAPRINE 7.5MG: Upheld

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

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

Decision rationale: The requested Cyclobenzaprine 7.5 mg is not medically necessary or appropriate. The Chronic Pain Medical Treatment Guidelines does not support the use of muscle relaxants in the management of chronic pain. The clinical documentation submitted for review does indicate that the injured worker has been on this medication for an extended duration of time. The Chronic Pain Medical Treatment Guidelines recommends muscle relaxants be used for short durations of treatment not to exceed 2 to 3 weeks for acute exacerbations of chronic pain. There is no documentation that the injured worker is experiencing an acute exacerbation of chronic pain. Additionally, the request as it is submitted does not clearly define a quantity or frequency of treatment. Therefore, the appropriateness of the request itself cannot be determined. As such, the requested Cyclobenzaprine 7.5mg is not medically necessary or appropriate.

OMEPRAZOLE 20MG: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines (NSAIDS) non-steroidal anti-inflammatory drugs, GI Symptoms & Cardiovascular Risk Page(s): 68.

Decision rationale: The requested Omeprazole 20 mg is not medically necessary or appropriate. The Chronic Pain Medical Treatment Guidelines recommends the ongoing use of gastrointestinal protectants be supported by documentation that the injured worker is at risk for developing gastrointestinal events due to medication usage. The clinical documentation submitted for review

does indicate that the injured worker has been on this medication for an extended duration of time. However, the documentation fails to provide ongoing assessment of the injured worker's gastrointestinal system to assess the injured worker's risk factors for gastrointestinal disturbances related to medication usage that would support ongoing use of this medication. Additionally, the request as it is submitted does not clearly identify a quantity or frequency of treatment. Therefore, the appropriateness of the request itself cannot be determined. As such, the requested Omeprazole 20 mg is not medically necessary or appropriate.