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| Case Number: | CM14-0015750 | | |
| Date Assigned: | 02/26/2014 | Date of Injury: | 03/20/2010 |
| Decision Date: | 08/07/2014 | UR Denial Date: | 01/07/2014 |
| Priority: | Standard | Application Received: | 02/07/2014 |

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 Occupational Medicine 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 30-year-old male who has submitted a claim for sacroiliac joint pain, lumbar discogenic pain, lumbar facetal syndrome, hip pain, and lumbosacral radiculopathy; associated with an industrial injury date of 03/20/2010. Medical records from 2013 were reviewed and showed that patient complained of low back pain, graded 5-6/10 radiating to the lower extremities. Pain is characterized as stabbing, cramping, shooting, and burning. Physical examination showed tenderness over the bilateral lumbar paraspinal region. Spasms were noted overlying the facet joints on the right. Range of motion was limited by pain. Straight leg raise test was positive on the right with less pain than before. Patient was alert, attentive and oriented, without signs of agitation, drowsiness, or of being in an overmedicated state. Treatment to date has included medications, TENS, physical therapy, and epidural steroid injections. Utilization review, dated 01/06/2014, denied the request for Omeprazole because the patient has no history of reflux or stomach complaints beyond heartburn, and does not have risk factors for serious gastric injury; denied the request for Nabumetone because patient has been on NSAIDs since prior to August which have been minimally effective, and guidelines do not support its long-term use; denied the request for Venlafaxine because there was no evidence of depression, anxiety, or neuropathic pain; and denied the request for Zolpidem because there was no sign of insomnia.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 prescription of Omeprazole 20mg #30: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms and cardiovascular risk.

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

Decision rationale: Omeprazole is a proton pump inhibitor that inhibits stomach acid production, used in the treatment of peptic ulcer disease and gastroesophageal reflux disease. Pages 68 to 69 of the CA MTUS Chronic Pain Medical Treatment Guidelines recommend the use of proton pump inhibitors in those individuals: using multiple NSAIDs; high dose NSAIDs; NSAIDs in conjunction with corticosteroids and/or anticoagulants; greater than 65 years of age; and those with history of peptic ulcer. In this case, the patient has been prescribed Omeprazole since at least July 2013, and complains of reflux symptoms due to pain medications. The medical records reviewed show that the patient is at risk for a gastrointestinal event. Therefore, the request for 1 prescription of Omeprazole 20mg #30 is medically necessary.

1 prescription of Nabumetone 750mg #60: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, Nabumetone Page(s): 67, 72-73.

Decision rationale: As stated on pages 67 and 72-73 of the CA MTUS Chronic Pain Medical Treatment Guidelines, NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain and they can cause gastrointestinal irritation or ulceration and renal or allergic problems. There is no evidence of long-term effectiveness for pain or function. In addition, guidelines state that Nabumetone is recommended for osteoarthritis. In this case, the patient has been prescribed NSAIDs since at least July 2013 for pain control. The most recent progress report dated 12/27/2013 showed improved pain control. Although reflux symptoms from pain medications are reported, patient was already prescribed Omeprazole. Therefore, the request for 1 prescription of Nabumetone 750mg #60 is medically necessary.

1 prescription of Venlafaxine 75mg #30: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Venlafaxine (Effexor).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain, Selective serotonin and norepinephrine reuptake inhibitors (SNRIs), SNRIs (serotonin and norepinephrine reuptake inhibitors) Page(s): 15, 105.

Decision rationale: As noted on pages 15 and 105 of the CA MTUS Chronic Pain Medical Treatment Guidelines, SNRIs are recommended as an option in first-line treatment of neuropathic pain, especially if tricyclics are ineffective, poorly tolerated, or contraindicated. In

this case, patient complains of low back pain with symptoms characterized as stabbing, cramping, shooting, and burning. He has been taking SNRIs since at least July 2013 for neuropathic pain. The most recent progress report dated 12/27/2013, showed decreased pain by VAS quantification. Therefore, the request for 1 prescription of Venlafaxine 75mg #30 is medically necessary.

1 prescription of Zolpidem 5mg: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Zolpidem.

Decision rationale: The CA MTUS does not address Ambien. Per the Strength of Evidence Hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Official Disability Guidelines (ODG) was used instead. The ODG states that Ambien (zolpidem) is a prescription short-acting nonbenzodiazepine hypnotic, which is approved for the short-term (usually 2 to 6 weeks) treatment of insomnia. Proper sleep hygiene is critical to the individual with chronic pain and often is hard to obtain. In this case, the patient has been taking Ambien for insomnia secondary to pain, since at least December 2013. However, in the most recent progress report dated 12/27/2013, the patient does not report night-time awakenings due to pain. In addition, medical records submitted for review failed to show objective evidence of improvement in the quality and duration of sleep. Lastly, the present request as submitted failed to indicate the number to be dispensed. Therefore, the request for Zolpidem 5mg is not medically necessary.