

<b>Case Number:</b>	CM14-0120746		
<b>Date Assigned:</b>	08/06/2014	<b>Date of Injury:</b>	01/27/2006
<b>Decision Date:</b>	10/03/2014	<b>UR Denial Date:</b>	07/17/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/30/2014

### 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 Physical Medicine & Rehabilitation, has a subspecialty in Pain 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:

Patient is a 58-year-old female with a 01/27/06 date of injury due to handling of heavy objects while rearranging the office. 8/5/14 progress report states that the patient presents for reevaluation of her neck pain. Her pain is 9/10 without medications and 5-6/10 with medications. This makes a big difference for her due to ability to work. She's using H-wave with therapy every day, which helps reduce some of the symptoms, decrease pain. She is requesting trigger point injections today due to increased pain and stress, as her medications have not been approved. Pain is in the neck, trapezius and upper extremities. Physical exam states cervical spine range of motion slightly reduced in all areas due to pain. Trigger point tenderness and muscle spasm in the traps and T1-2 and T2-3 aspirin as muscles. Sensation is diminished bilaterally in the fourth and fifth fingers. Current prescriptions state Norco, omeprazole, baclofen, Trazodone, Zolpidem, docusate sodium, lidocaine patches, alprazolam, Milnacipran, Vilazodone. Impressions state chronic pain syndrome, carpal tunnel syndrome, numbness, muscle pain, depression, anxiety, cervical radiculopathy, and degenerative disk disease in cervical spine, neck pain, cervical postlaminectomy syndrome, and elbow tendinitis. 06/26/14 psychology progress report states that the patient's condition is exacerbated due to chronic pain, recurrent episodes of depression and anxiety as well as nonmedical withdrawal from psychiatric medications for 20 days. The report states that the medications had helped her return to work and participate in daily activities, however recent denial of medications resulted in a great deal of anxiety and fear of helplessness. Diagnoses are major depression, anxiety NOS, pain disorder associated with both psychological factors and general medical condition. Progress note dated 05/14/14 states that patient completed 6 visits of physical therapy and her pain is better and she doesn't really need any trigger point injections. Elbow pain has almost resolved. She is doing exercises and stretching the back, which helped. Xanax helps for anxiety but she uses less now

because she has her usual antidepressants. Trazodone helps with sleep and she has been using it less since he started using the H. wave. Baclofen and Lidoderm patches help for spasm and tenderness between TPI (Trigger Point Injections) is so she can continue working. She still gets numbness in the hands and pain becomes worse with prolonged or repetitive activity. However the patient is reporting at 4/10 pain with availability of old prescribed medications. 06/12/12 report states the patient has symptoms of acid reflux and nausea. This report also states that the patient was able to discontinue Xanax by using a combination of baclofen and Zanaflex. Prilosec has successfully eliminated the acid reflux she was experiencing. This report also states that the combination of medications the patient is on is quite unusual and should be addressed by pharmacist to consolidate and eliminate some of these medications. She should be taken off all NSAID's and that way she may not need to take Prilosec.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Omeprazole DR 20mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAID'S, GI Symptoms and Cardiovascular Risk Page(s): 68-69.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) (Pain Chapter), NSAIDs, GI symptoms & cardiovascular risk, Proton pump inhibitors (PPIs).

**Decision rationale:** The review of the case documentation reveals the mentioned gastroenterology/internal medicine QME from 06/18/13 by [REDACTED]. This report states diagnosis of acid reflux. It does NOT indicate a prior peptic ulcer. Moreover, the medical history section of the QME (Qualified Medical Examination) report states: "no history of peptic ulcer disease, ulcerative colitis or colon cancer. She has acid reflux for which he takes Prilosec. She denies history of gastrointestinal bleeding." QME (Qualified Medical Examination) report's "future medical treatment section" states: "For GI symptoms [REDACTED] should be provided with Prilosec, probiotics and stool softeners. Anti-inflammatory medications should not be prescribed for [REDACTED]." The latter statement made by QME does not mean that the patient needs to be treated with PPIs for an infinite period of time. By controlling the production of acid, proton pump inhibitors are able to facilitate an environment in which the mucous membranes of the GI tract would be able to heal. In other words, treatment with PPIs does have endpoints, resulting in recovery and dissolution of symptoms. That being said, NSAID therapy has been discontinued, thus eliminating the cause and source of the patient's GI symptoms (also per QME). More than 12 months have passed since that QME. There are no current esophageo-gastric symptoms or examination/evaluation described or discussed in the recent reports. At this point the medical necessity for omeprazole has not been established, as there are no recently documented symptoms of gastritis, esophagitis, acid reflux, ulceration, pertinent to the inflammatory or erosive conditions of the esophago-gastro-duodenal segment. Bowel movement and gas related symptoms are irrelevant in the context of this request and are not addressed by

PPIs, like omeprazole (Prilosec). Therefore, the Omeprazole DR 20mg #60 is not medically necessary and appropriate.

**Norco 10/325mg #180:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for use; Opioids, Specific Drug List; Weaning of.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs; substance misuse Page(s): 81; 79-80.

**Decision rationale:** Patient has a 2006 date of injury and the records indicate the importance of analgesia achieved by Norco for this patient's functioning. Reduction in pain scores has been described and ability to perform ADLs (Activities of Daily Living) as well as improved work performance has also been documented. Urine drug screen is presented. In the context of this request, the prescription of Norco is medically necessary. However, the review of the patient's medication list reveals several drug categories, each being represented by multiple medications. There are several antidepressants prescribed at the same time, several muscle relaxants. As prior QME reports have noted, it is imperative to reassess the patient's prescription list and to make adjustments in terms of elimination or consolidation of same class medications. This would relieve the stress off the patient's organism, and specifically her GI tract. Most importantly, determining the most efficient approach to antidepressant therapy would establish better control over neuropathic pain, thus allowing initiating the weaning of Norco, for which the patient has likely developed dependence already. Weaning of Norco in the near future is imperative. Therefore, the request of Norco 10/325mg #180 is medically necessary and appropriate.