

Case Number:	CM14-0135513		
Date Assigned:	08/29/2014	Date of Injury:	09/08/2008
Decision Date:	10/30/2014	UR Denial Date:	08/07/2014
Priority:	Standard	Application Received:	08/21/2014

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 Anesthesiology, has a subspecialty in Pain Medicine 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 53 year old male who sustained an injury on 09/08/08 while digging out a sprinkler line. The injured worker had previously attended both physical and chiropractic therapy and received injection therapy. The injured worker is status post partial medial and lateral meniscectomy of the left knee in July of 2011. This was followed by a left labral repair and osteoplasty in April of 2013. The injured worker has been followed for ongoing chronic pain in the back and left lower extremity as well as bilateral knee pain. The injured worker was seen on 07/31/14 for ongoing pain in the left shoulder and right knee that was worsening. The physical exam noted tenderness to palpation in the lumbar region with a positive straight leg raise. There was tenderness to palpation over the hips, left shoulder and right knee. The injured worker's requested medications were denied on 08/07/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS, CRITERIA FOR USE Page(s): 88-89.

Decision rationale: Overall, there is insufficient evidence in the clinical literature that long term use of narcotic medications results in any functional improvement. The clinical documentation provided for review did not identify any particular functional improvement obtained with the ongoing use of Norco. No specific pain improvement was attributed to the use of this medication. The clinical documentation also did not include any compliance measures such as toxicology testing or long term opiate risk assessments (COMM/SOAPP) to determine risk stratification for this injured worker. This would be indicated for Norco given the long term use of this medication. Furthermore, the request is not specific in regards to dose, quantity, frequency or duration. As there is insufficient evidence to support the ongoing use of Norco, this reviewer would not have recommended this request as medically necessary.

Protonix: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines: NSAIDs, GI symptoms an.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) PAIN CHAPTER, PROTON PUMP INHIBITORS

Decision rationale: In review of the clinical documentation provided, the requested Protonix would not be supported as medically necessary per current evidence based guideline recommendations. The clinical records provided for review did not discuss any side effects from oral medication usage including gastritis or acid reflux. There was no other documentation provided to support a diagnosis of gastroesophageal reflux disease. Furthermore, the request is not specific in regards to dose, quantity, frequency, or duration. Given the lack of any clinical indication for the use of a proton pump inhibitor, this reviewer would not have recommended this request as medically necessary.