

Case Number:	CM14-0136832		
Date Assigned:	09/03/2014	Date of Injury:	07/22/1996
Decision Date:	10/02/2014	UR Denial Date:	08/15/2014
Priority:	Standard	Application Received:	08/25/2014

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 and Rehabilitation, has a subspecialty in Interventional Spine 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 54-year-old female with date of injury of 04/22/1996. The listed diagnoses per [REDACTED] dated 05/30/2014 are: 1. Gastritis, chronic. 2. Displacement of the lumbar disk without myelopathy. 3. Stenosis of the lumbar spine. 4. Lumbar radiculopathy. 5. Degenerative disk disease, lumbar spine. 6. Cervicalgia. 7. Pain in the joint, shoulder region. 8. Carpal tunnel syndrome. 9. Headache. 10. Post laminectomy syndrome, cervical region. 11. Unspecified myalgia and myositis. According to this report, the patient complains of chronic severe pain related to her history of intractable headaches, neck, and lower back pain. The patient underwent a cervical fusion in 2000 and in 2010. The patient reports her pain level 10/10 without medication and 7/10 with medications. The medications prescribed are keeping the patient functional allowing for increased mobility, intolerance of ADLs and home exercises. No side effects were associated with these. The physical exam shows the patient is well nourished and well hydrated in no acute distress. Neurologic reflexes are 2+ and symmetric. Injection sites in the cervical spine are well healed with no signs of infection. There is some tenderness in the suboccipital regions bilaterally with depressed affect. Tenderness was noted in the lower back, right hip, and right thigh. Sitting straight leg raise is positive bilaterally. Decreased right upper extremity and right lower extremity strength noted. Sensory exam shows decreased left C5, left C6, left L4, right C5, right C6, right C7, right L4, and right L5 sensation to pinprick. The Utilization Review denied the request on 05/15/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325mg #180: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines On-Going Management, Opioids, long-term assessment Page(s): 78, 88, 89.

Decision rationale: This patient presents with neck and lower back pain. The treater is requesting Norco 10/325 mg, #180. For chronic opiate use, the MTUS Guidelines page 88 and 89 require functioning documentation using a numerical scale or a validated instrument at least once every 6 months. MTUS page 78 also requires documentation of the 4As including analgesia, ADLs, adverse side effects, and aberrant behavior as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medications to work, and duration of pain relief. The records show that the patient was prescribed Norco on 01/14/2014. However, it is unclear if the patient was prescribed this medication prior to this report. The treater notes the patient's pain level is 10/10 without medications and 7/10 with medications. He also states that the patient prescribed medications are keeping the patient functional, allowing for increased mobility, and tolerance of ADLs and home exercises. No side effects were noted. The patient's current work status is permanent and stationary as of 06/02/2014. The urine drug screen dated 04/02/2014 shows inconsistent results with prescribed medications but the treater does not address this. There is no evidence that the patient is actually taking the medication and the possibility of drug diversion is not addressed by the treater. There are no specific discussion regarding the patient's functional improvements either. Recommendation is for denial.

Topomax 25mg #60: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topamax, Antiepilepsy drugs (AEDs) Page(s): 21, 16, 17.

Decision rationale: This patient presents with neck and lower back pain. The treater is requesting Topamax 25 mg, #60. The MTUS Guidelines page 21 on Topamax states that it is recommended for neuropathic pain when other anticonvulsants have failed. Furthermore, MTUS page 16 and 17 on anti-epilepsy drugs (AEDs) states that it is recommended for neuropathic pain, but there is a lack of consensus on treatment. Most trials have been directed at postherpetic neuralgia and painful polyneuropathy. The records show that the patient was prescribed Topamax on 01/14/2014. The patient was prescribed Topamax for migraine prophylaxis and chronic pain. The treater notes medication efficacy stating "medications prescribed are medically necessary as they provide analgesia, help patient to better perform ADLs, improved effect, and overall quality of life without any intolerable side effects." In this case, the treater

documents adequate documentation of medication efficacy. Recommendation is for authorization.

Omeprazole 20mg #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, GI symptoms & cardiovascular risk Page(s): 68-69.

Decision rationale: This patient presents with neck and lower back pain. The treater is requesting omeprazole 20 mg, #60. The MTUS Guidelines page 68 and 69 on NSAIDs, GI symptoms, and cardiovascular risk states that it is recommended with precaution for patients at risk for gastrointestinal events; ages greater than 65; history of peptic ulcers; GI bleed or perforation; concurrent use of ASA or corticosteroids, and/or anticoagulants; high dose multiple NSAIDs. The records show that the patient was prescribed omeprazole on 01/14/2014. In the same report, the treater notes chronic gastritis and induced-reflux/gastritis. Given that the treater has documented gastrointestinal events, the continued use of omeprazole is medically necessary. Recommendation is for authorization.

Diphenhydramine HCL 50mg #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, sedating anti-histamines

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Recommend that treatment be based on the etiology, with the medications. See Insomnia. ODG Psychotherapy Guidelines

Decision rationale: This patient presents with neck and lower back pain. The provider is requesting diphenhydramine HCl 50 mg, #30. The MTUS and ACOEM Guidelines do not address this request. However, ODG Guidelines under diphenhydramine states that sedating antihistamines are not recommended for long term insomnia treatment. The AGS Updated Beers Criteria for inappropriate medication use includes diphenhydramine. ODG also notes under insomnia treatment, pharmacological agent should only be used after a careful evaluation of potential cause of sleep disturbance. Failure of sleep disturbance to resolve in 7- to 10-day period may indicate a psychiatric and/or medical illness. The records show that the patient was prescribed diphenhydramine on 04/02/2014. The provider does not mention sleep disturbance or reports of sleep difficulty. Furthermore, ODG does not recommend the use of sedating antihistamines for long term insomnia treatment. Recommendation is for not medically necessary.