

Case Number:	CM14-0158053		
Date Assigned:	10/01/2014	Date of Injury:	01/12/2009
Decision Date:	11/06/2014	UR Denial Date:	09/03/2014
Priority:	Standard	Application Received:	09/26/2014

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 Texas & Oklahoma. 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 35-year-old male who reported an injury after being involved in a physical altercation on 01/12/2009. On 08/26/2014, his diagnoses included degeneration of cervical spine intervertebral disc, cervical disc displacement, cervical radiculitis, and diabetes mellitus. His complaints included neck and left shoulder pain that radiated into the left arm with paresthesias, numbness, and weakness. He was noted to be status post cervical fusion. He was also suffering from severe headaches described as a "gripping device" associated with blurred vision, mild photo/noise/smell sensitivity, and nausea/vomiting. He rated his overall pain level at 8/10 to 9/10. His medications include Prilosec 20 mg, Oxycontin ER 40 mg, Percocet 10/325 mg, Anaprox DS 550 mg, Cyclobenzaprine 10 mg, and Glucosamine 500 mg. There was no rationale or Request for Authorization included in the injured worker's chart.

IMR ISSUES, DECISIONS AND RATIONALES

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

Prilosec 20mg #60: 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)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs), GI symptoms & cardiovascular risk Page(s): 68-69.

Decision rationale: The request for Prilosec 20 mg #60 is not medically necessary. The California MTUS Guidelines suggest that proton pump inhibitors, which include Prilosec, may be recommended, but clinicians should weigh the indication for NSAIDs against GI risk factors. Those factors determining if a patient is at risk for gastrointestinal events includes age greater than 65 years, history of peptic ulcer, GI bleeding, or perforation, concurrent use of aspirin, corticosteroids, and/or an anticoagulant, or high dose/multiple NSAID use. Prilosec is used in the treatment of dyspepsia, peptic ulcer disease, gastroesophageal reflux disease, or laryngopharyngeal reflux. This injured worker did not have any of the above diagnoses, nor did he meet any of the qualifying criteria for risks for gastrointestinal events. Additionally, the request did not specify frequency of administration. Therefore, this request for Prilosec 20 mg #60 is not medically necessary.

Oxycontin ER 40mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-95.

Decision rationale: The request for OxyContin ER 40 mg #60 is not medically necessary. The California MTUS Guidelines recommend ongoing review of opioid use including documentation of pain relief, functional status, appropriate medication use, and side effects. It should include current pain and intensity of pain before and after taking the opioid. Satisfactory response to treatment may be indicated by decreased pain, increased level of function, or improved quality of life. In most cases, analgesic treatment should begin with acetaminophen, aspirin, NSAIDs, antidepressants, and/or anticonvulsants. Long term use may result in immunological or endocrine problems. There was no documentation in the submitted chart regarding appropriate long term monitoring/evaluations, including side effects, failed trials of NSAIDs, aspirin, acetaminophen, antidepressants or anticonvulsants, quantified efficacy, or drug screens. Additionally, there was no frequency specified in the request. Since this injured worker was taking more than 1 opioid medication, without the frequency, the morphine equivalency dosage could not be calculated. Therefore, this request for OxyContin ER 40 mg #60 is not medically necessary.

Percocet 10/325mg #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-95.

Decision rationale: The request for Percocet 10/325 mg #120 is not medically necessary. The California MTUS Guidelines recommend ongoing review of opioid use including documentation of pain relief, functional status, appropriate medication use, and side effects. It should include current pain and intensity of pain before and after taking the opioid. Satisfactory response to treatment may be indicated by decreased pain, increased level of function, or improved quality of life. In most cases, analgesic treatment should begin with acetaminophen, aspirin, NSAIDs, antidepressants, and/or anticonvulsants. Long term use may result in immunological or endocrine problems. There was no documentation in the submitted chart regarding appropriate long term monitoring/ evaluations, including side effects, failed trials of NSAIDs, aspirin, acetaminophen, antidepressants or anticonvulsants, quantified efficacy, or drug screens. Additionally, there was no frequency specified in the request. Since this injured worker was taking more than 1 opioid medication, without the frequency, the morphine equivalency dosage could not be calculated. Therefore, this request for Percocet 10/325 mg #120 is not medically necessary.

Glucosamine 550mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 50. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee & Leg, Glucosamine/ Chondroitin (for knee arthritis).

Decision rationale: The request for Glucosamine 550 mg #30 is not medically necessary. The Official Disability Guidelines recommend Glucosamine as an option, but only in the Glucosamine sulfate form. It has a low risk profile in patients with moderate osteoarthritis knee pain. Several studies have demonstrated a highly significant efficacy of Glucosamine on all outcomes, including joint space narrowing, pain, mobility, safety, and response to treatment. This request did not specify the Glucosamine sulfate form of Glucosamine. Additionally, there was no frequency of administration included in the request. Therefore, this request for Glucosamine 550 mg #30 is not medically necessary.