

Case Number:	CM14-0167459		
Date Assigned:	10/28/2014	Date of Injury:	01/31/2009
Decision Date:	12/04/2014	UR Denial Date:	09/16/2014
Priority:	Standard	Application Received:	10/10/2014

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 Orthopedic Spine Surgery 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 injured worker is a 65-year-old female who reported an injury on 01/31/2009. The mechanism of injury was not stated. The current diagnoses include a cervical myoligamentous sprain/strain, status post C5-6 and C6-7 anterior cervical discectomy and fusion on 02/06/2008, bilateral upper extremity radiculopathy, status post left carpal tunnel release and TFCC repair, reactionary depression and anxiety, status post cervical spinal cord stimulator implant on 10/27/2011 and revision on 01/20/2014, and medication induced gastritis. The injured worker was evaluated on 10/03/2014, with complaints of ongoing neck pain and cervicogenic headaches with radiation into the bilateral upper extremities. Previous conservative treatment is noted to include medication management and trigger point injections. The current medication regimen includes Methadone 5 mg, Flexeril 10 mg, Prozac 20 mg, Restoril 15 mg, Prilosec 20 mg, and Topamax 25 mg. Physical examination revealed tenderness to palpation of the posterior cervical musculature, increased muscle rigidity, focal tenderness with a twitch response, decreased range of motion, decreased sensation in the C6 distribution, and 1+ deep tendon reflexes bilaterally. Treatment recommendations included continuation of the current medication regimen. It was noted that the injured worker was continuing to lower the dose of methadone. A Request for Authorization form was then submitted on 10/03/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Methadone 5mg #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 61-62.

Decision rationale: The California MTUS Guidelines state "Methadone is recommended as a second line drug for moderate to severe pain if the potential benefit outweighs the risk." The injured worker has continuously utilized this medication since 12/2013. There is no documentation of objective functional improvement. Therefore, the ongoing use cannot be determined as medically appropriate. There is also no frequency listed in the current request. As such, the request is not medically necessary.

Flexeril 10mg #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 Page(s): 63-66.

Decision rationale: The California MTUS Guidelines state "muscle relaxants are recommended as a nonsedating second line option for short term treatment of acute exacerbations." Flexeril should not be used for longer than 2 to 3 weeks. There is no frequency listed in the request. Therefore, the request is not medically necessary.

Anaprox DS 550mg: Upheld

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

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

Decision rationale: The California MTUS Guidelines state "NSAIDs (Non-Steroidal Anti-Inflammatory Drugs) are recommended for osteoarthritis at the lowest dose for the shortest period in patients with moderate to severe pain." For acute exacerbations of chronic pain, NSAIDs are recommended as a second line option after acetaminophen. There is no frequency or quantity listed in the request. Therefore, the request is not medically necessary.

Prilosec 20mg: Upheld

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

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

Decision rationale: The California MTUS Guidelines state "proton pump inhibitors are recommended for patients at intermediate or high risk for gastrointestinal events." Patients with no risk factor and no cardiovascular disease do not require the use of a proton pump inhibitor. There is no documentation of cardiovascular disease or increased risk factors for gastrointestinal events. Therefore, the current request is not medically appropriate. There is also no frequency or quantity listed in the request. As such, the request is not medically necessary.

LidoPro 121mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113..

Decision rationale: The California MTUS Guidelines state "topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety." They are primarily recommended for neuropathic pain when anticonvulsants and antidepressants have failed. There is no documentation of a failure to respond to first line oral medication prior to the initiation of a topical analgesic. There is also no frequency or quantity listed in the request. As such, the request is not medically necessary.

Retrospective Prilosec 20mg (DOS 3/21/14, 2/7/14, 1/8/14): Upheld

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

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

Decision rationale: The California MTUS Guidelines state "proton pump inhibitors are recommended for patients at intermediate or high risk for gastrointestinal events." Patients with no risk factor and no cardiovascular disease do not require the use of a proton pump inhibitor. There is no documentation of cardiovascular disease or increased risk factors for gastrointestinal events. Therefore, the current request is not medically appropriate. There is also no frequency or quantity listed in the request. As such, the request is not medically necessary.

Retrospective Prozac 20mg (DOS 3/21/14, 2/7/14, 1/8/14): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 107.

Decision rationale: The California MTUS Guidelines state "SSRIs are not recommended as a treatment for chronic pain, but may have a role in treating secondary depression." The injured worker does maintain a diagnosis of depression; however, the injured worker has continuously utilized this medication since 01/2014 without any evidence of objective functional improvement. There is no frequency or quantity listed in the request. Therefore, the request is not medically necessary.

Retrospective Quazepam/Doral 15mg (DOS 3/21/14, 2/7/14, 1/8/14): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 24.

Decision rationale: The California MTUS Guidelines state "benzodiazepines are not recommended for long term use because long term efficacy is unproven, and there is a risk for dependence." The injured worker has continuously utilized this medication since 01/2014 without any evidence of objective functional improvement. There is no frequency or quantity listed in the request. As such, the request is not medically necessary.

Retrospective Remeron 15mg (DOS 1/8/14): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 13-16.

Decision rationale: The California MTUS Guidelines state "antidepressants are recommended as a first line option for neuropathic pain and as a possibility for non-neuropathic pain." Tricyclics are generally considered a first line agent unless they are ineffective, poorly tolerated, or contraindicated. The injured worker has continuously utilized this medication since 01/2014 without any evidence of objective functional improvement. There is also no frequency or quantity listed in the request. Therefore, the request is not medically necessary.