

Case Number:	CM14-0024675		
Date Assigned:	06/11/2014	Date of Injury:	08/12/2011
Decision Date:	07/15/2014	UR Denial Date:	02/21/2014
Priority:	Standard	Application Received:	02/26/2014

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 and Rehabilitation and is licensed to practice in Nevada. 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 employee is a 49-year-old female who reported a work-related injury on August 12, 2011. The mechanism of injury was reported to be a trip and fall injuring the neck and lower back. The most recent medical examination, dated March 18, 2014, stated that the injured employee complained of low back pain radiating to both legs and feet. Current medications were stated to include tramadol, hydrocodone, tizanidine, zolpidem, omeprazole, and naproxen. The physical examination on this date noted lumbar paraspinal muscle tenderness as well as muscle spasms on the right side. There was decreased lumbar spine range of motion. Neurological examination of the lower extremities noted normal sensation, muscle strength and reflexes in the lower extremities. There was a positive right-sided straight leg raise. There was a diagnosis of low back pain with right lower extremity radicular pain and cervical multilevel degenerative disc disease with right upper extremity radicular pain. It was stated that conservative measures have not helped and epidural steroid injections were recommended. A utilization management review, dated February 24, 2014, did not certify the use of Anaprox or Atarax.

IMR ISSUES, DECISIONS AND RATIONALES

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

MEDS X 1 ANAPROX 550MG #90: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 (EFFECTIVE JULY 18, 2009), NSAIDS Page(s): 67 OF 127.

Decision rationale: Anaprox is an anti-inflammatory medication used to treat general anti-inflammatory conditions. It is not clear in the medical record why this particular anti-inflammatory has been chosen over others. While the notes on March 18, 2014 state that the current medications prescribed are appropriate, there is no mention of their efficacy. Without any evidence of the benefit of this medication over generic preparations, this request for Anaprox is not medically necessary.

MEDS X 2; ATARAX 25MG #60: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness and Stress, Insomnia Treatment.

Decision rationale: Atarax is an antihistamine medication. It is unclear from the attached medical record what the intention of this medication use is. However, it may very well be used for night-time insomnia. The Official Disability Guidelines states that treatment for insomnia be based on the etiology and that pharmacological agents should only be used after careful evaluation of potential causes of sleep disturbance. The medical record does not indicate the failure of other nonpharmacological trials for proper sleep such as general sleep hygiene. This request for Atarax is not medically necessary.

PRILOSEC 20MG #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 (EFFECTIVE JULY 18, 2009), NSAIDS, GI.SYMPTOMS AND CARDIOVASCULAR RISK Page(s): 68 OF 127.

Decision rationale: Prilosec is a proton pump inhibitor often used to treat gastric upset secondary to other medications such as non-steroidal anti-inflammatory medications (NSAIDs). There is no documentation in the attached medical record that the injured employee is experiencing any gastrointestinal (GI) symptoms secondary to NSAID usage. Without this specific justification this request for Prilosec is not medically necessary.