MAXIMUS Federal Services

Case Number:	CM14-0036545		
Date Assigned:	08/06/2014	Date of Injury:	04/03/2011
Decision Date:	09/10/2014	UR Denial Date:	02/26/2014
Priority:	Standard	Application Received:	03/25/2014

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 Neurology 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 43 year-old male with most documents indicating a date of injury (DOI) as 4/3/2011. A Request for Information document dated 6/25/2014 notes the DOI as 12/12/2009. No mechanism of injury is reported in the documents reviewed for this Independent Medical Review. The IW suffers low back and bilateral leg pain from degenerative lumbosacral intervertebral disks and spinal stenosis without objective findings of radiculopathy, and has been treated primarily with Norco and Naproxen since at least 9/17/2013 (earliest record available for this review), and that Soma had been used but was discontinued also at that date. A trial of Trazodone was tried (15/2013 - 1/7/2014) which the IW reported as ineffective. Records (Progress Report dated 9/17/2013) demonstrate that the treating physician initiated a proton-pump inhibitor medication (first Prilosec and later Protonix) for prophylactic prevention of GI events which might result with NSAID use. The Primary Treating Physician's Progress Report of 2/4/2014 indicates that Naproxen prescriptions were suspended at that date. In a note from a Utilization Review Physician (UR dated 2/26/2014), it is apparent that the requesting physician confirmed that Naproxen use had indeed been stopped, even as a Prilosec re-fill had been requested for approval on 2/24/2014. This request was non-certified in that UR dated 2/26/2014.Additionally, physicians' reports indicate that the IW suffers nausea and decreased appetite associated with his pain medication use, and the earliest record provided (9/17/2013) indicates that the IW has been using Phenergan since at least August 2013. An RFA for Phenergan 25 mg #60 re-fill was made on 2/24/2014 and partially certified (as QTY #45) in the UR dated 2/26/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Phenergan 25mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Goodman and Gilman's, The Pharmacological Basis for Therapeutics, 12th Edition.

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, Antiemetics (for opioid use).

Decision rationale: The Official Disability Guidelines, Pain chapter, Antiemetics (for opioid use) indicates clearly that antiemetics are not recommended for nausea and vomiting secondary to chronic opioid use. Phenergan is a phenothiazine recommended as a sedative and antiemetic in pre- and post-operative applications. Prolonged ("chronic") use of this medication may result in tardive dyskinesia and choreoathetoid movements and in some instances these effects may become irreversible. Multiple central nervous system effects with its use include somnolence, confusion, and sedation. Studies of antiemetics used to treat nausea and vomiting associated with opioid use have been limited to patients using opioids to manage cancer pain or for those using opioids for acute/postoperative treatment. There are no sufficient high-quality studies to support any one treatment for opioid-use induced nausea in non-malignant chronic pain populations. While it is common for patients to experience nausea and vomiting upon initiating an opioid medication, studies show that these side effects usually diminish over the first days/weeks of stable, continued use. Where these side-effects persist, further evaluation for other symptom etiologies is necessary. (For example, gastroparesis such as that resulting from diabetes should be ruled out.) Therefore, this request is not medically necessary.

Prilosec 20mg #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68.

Decision rationale: Where there is a gastrointestinal risk for an adverse event, the MTUS Chronic Pain Management Treatment Guidelines recommends use of a proton pump inhibitor, such as Prilosec. In this case, however, the reports do not cite that this IW has any of the risk factors (i.e., age over 65 years, history of peptic ulcer, concurrent use of ASA, corticosteroids and/or anticoagulants nor high-dose/multiple NSAIDs use) which would warrant use of a proton pump inhibitor (MTUS Guidelines, NSAIDs, GI symptoms & cardiovascular risk, p. 68). Furthermore, reports and physician's notes indicate that the IW has suspended use of NSAIDs (i.e., Naproxen). The request for Prilosec 20 mg #30 is not medically unnecessary.