

<b>Case Number:</b>	CM14-0037059		
<b>Date Assigned:</b>	06/25/2014	<b>Date of Injury:</b>	07/06/2009
<b>Decision Date:</b>	07/25/2014	<b>UR Denial Date:</b>	02/28/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/27/2014

### 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 Occupational Medicine 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 claimant had a urine drug screen on 11/05/13 and Hydrocodone and citalopram were noted to be present. On 12/05/13, she saw [REDACTED] and was prescribed Norco 10/325 mg #180, Ultram ER, Anaprox, Prilosec 20 mg #60, and Wellbutrin. She was using 4-6 Norco tablets per day. She was also using Prilosec 20 mg twice a day. She was taking the same doses on 01/07/14. Her pain was 8/10 in intensity. Her medications were refilled. Cervical ESI was recommended. She saw [REDACTED] on 02/07/14 and had ongoing pain in her neck with associated cervicogenic headaches. She had pain radiating to both extremities. She also had pain in her left knee. She had tenderness around the posterior cervical spine and muscle and shoulder regions. There was swelling and she was wearing a rigid left knee brace. There was obvious atrophy of the left thigh. She had ongoing pain in her neck with cervicogenic headaches and pain radiating down to both upper extremities, worse on the right. Conservative treatment was recommended by [REDACTED]. She was receiving cognitive behavioral psychotherapy sessions and remained on Wellbutrin and Xanax for anxiety. She was taking Norco 4-5 per day which helped her pain and function. She was also using Ultram ER. She was taking Anaprox and experienced less GI discomfort while on Prilosec. Cervical ESI was recommended and trigger point injections were done. The request for Norco on 02/07/14 was denied due to the absence of documentation of a dosage schedule or the number of pills dispensed. Prilosec was modified to #30 from #60. She was in mild distress and had an antalgic gait favoring the left lower extremity. There was tenderness to palpation about the cervical spine with decreased range of motion but good strength. Her low back also had decreased range of motion but no neurologic deficits. She was prescribed Norco 10/325, #180 and was to take 5 tablets a day. Prilosec was continued at the same dose. She was given #60 of Prilosec per the treatment plan.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Prilosec 20mg QTY :30.00:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68-69.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Proton pump inhibitors Page(s): 102.

**Decision rationale:** The history and documentation support the request for Prilosec at this time. The California MTUS state on page 102, PPIs determine if the patient is at risk for gastrointestinal events over the age of 65 years, history of peptic ulcer, GI bleeding or perforation, concurrent use of ASA, corticosteroids, and/or an anticoagulant or high dose/multiple NSAID. Recommendations for patients with no risk factor and no cardiovascular disease are: Non-selective NSAIDs. Patients at intermediate risk for gastrointestinal events and no cardiovascular disease: A non-selective NSAID with either a PPI (Proton Pump Inhibitor, for example, 20 mg Omeprazole daily) or Misoprostol (200 g four times daily) or a Cox-2 selective agent. In this case, there is documentation that the claimant is taking Anaprox on a chronic basis and has relief of GI symptoms with the use of Prilosec. Therefore, it is reasonable, since Anaprox is being continued, for her to also continue the use of Prilosec on a prophylactic basis. The medical necessity of this request can be supported as medically appropriate and reasonable.

**Norco 10/325mg (Retro DOS 2/7/14):** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for chronic pain Page(s): 80-81.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for Chronic Pain Page(s): 110.

**Decision rationale:** The history and documentation do not objectively support the request for ongoing use of the opioid, Norco. The MTUS outlines several components of initiating and continuing opioid treatment and states a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Before initiating therapy, the patient should set goals, and the continued use of opioids should be contingent on meeting these goals. These records note that the claimant has been using Norco regularly for a prolonged period of time, but there is no documentation of trials and subsequent failure of or intolerance to first-line drugs such as acetaminophen or nonsteroidal anti-inflammatory drugs. MTUS further explains pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. There is also no indication that periodic monitoring of the claimant's pattern of use and a response to this medication, including assessment of pain relief and functional benefit, has been or will be done. There is no evidence that she has been involved in an ongoing rehab program to help maintain any benefits she received from treatment

measures. Additionally, the 4A's "analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors" should be followed and documented per the guidelines. There is no evidence that a signed pain agreement is on file at the provider's office and no evidence that a pain diary has been recommended. As such, the request is not medically necessary.