

Case Number:	CM14-0037742		
Date Assigned:	06/25/2014	Date of Injury:	02/21/2012
Decision Date:	08/28/2014	UR Denial Date:	03/24/2014
Priority:	Standard	Application Received:	03/28/2014

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 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 30 year-old female who was reportedly injured on February 21, 2012. The mechanism of injury is noted as a lifting event resulting in low back pain. The most recent progress note dated March 4, 2014, indicates that there are ongoing complaints of low back pain. The physical examination demonstrated a 5'4", 165 pound individual who is normotensive. Straight leg raising was slightly reduced. A motor and sensory decrease in left lower extremity is reported. Diagnostic imaging studies objectified a normal appearing lumbar spine evaluation. Slight disc changes are noted on Magnetic resonance imaging. Previous treatment includes electrodiagnostic studies completed on March 5, 2014. A normal nerve conduction study is reported and changes associated with a possible chronic L4-5 radiculopathy. Also noted was physical therapy which was reportedly by the overall symptomology. A request had been made for multiple medications and was not certified in the pre-authorization process on March 24, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Omeprazole DR 20 mg # 30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 66-68.

Decision rationale: (Omeprazole) is a proton pump inhibitor useful for the treatment of gastroesophageal reflux disease (GERD) and is considered a gastric protectant for individuals utilizing non-steroidal anti-inflammatory medications. There is no indication in the record provided of a gastrointestinal disorder. There is no notation in the progress notes indicating any such complaints. Additionally, the claimant does not have a significant risk factor for potential gastrointestinal complications as outlined by the California Medical Treatment Utilization Schedule. Therefore, the request for Omeprazole DR 20 mg # 30 is not medically necessary and appropriate.

Fluoxetine HCL 20mg #30: 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) Mental Illness & Stress.

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 updated July, 2014.

Decision rationale: When noting the date of injury, the reported mechanism of injury, the minimal findings noted on magnetic resonance imaging and the lack of any significant pathology objectified on electrodiagnostic testing tempered by the filing. The physical examination reveals there is no clinical information presented to suggest a depression. Therefore, based on the limited clinical fracture presented for review the medical necessity of medication has not been established.

Alprazolam 1mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain.

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

Decision rationale: This medication is not recommended for long-term use because the long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to four weeks. Their range of action includes sedative/hypnotic, anxiolytic, anticonvulsant, and muscle relaxant. Chronic benzodiazepines are the treatment of choice in very few conditions. Tolerance to hypnotic effects develops rapidly. Tolerance to anxiolytic effects occurs within months and long-term use may actually increase anxiety. Therefore, based on the limited clinical information presented for review, the medical necessity of this medication has not been established. As such, the request for Alprazolam 1mg #30 is not medically necessary and appropriate.

Gabapentin 300mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs Page(s): 18.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 16-18.

Decision rationale: This medication is an anti-epilepsy drug with a recommendation as outlined in the California Medical Treatment Utilization Schedule to address neuropathic pain (pain due to nerve damage). When noting the minimal changes identified on magnetic resonance imaging and the lack of specific pathology on electrodiagnostic assessment, this does not appear to be objective occasion of such a finding. While noting a lack of consensus on the use of this medication for neuropathic pain, the off label use has been endorsed. Primarily directed towards postherpetic neuralgia and painful polyneuropathy (and neither of those diagnoses are present in this clinical situation) some success is noted for chronic back pain. However, no such efficacy has been objectified. Therefore, there is no medical necessity established for the continued use of this preparation. As such, the request for Gabapentin 300mg #30 is not medically necessary and appropriate.

Hydrocodone/Acetamenophin 10/325mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, specific drug list Page(s): 91.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 75-78.

Decision rationale: Norco (Hydrocodone/acetaminophen) is a short-acting opioid combined with acetaminophen. California Medical Treatment Utilization Schedule supports short-acting opiates for the short-term management of moderate to severe breakthrough pain. The short-term period has been exceeded. Management of opiate medications should include the lowest possible dose to improve pain and function, as well as the ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects. There is no notation of any efficacy, improvement in functionality, or increased activity of daily living parameters. As such, the request for Hydrocodone/Acetamenophin 10/325mg #60 is not medically necessary and appropriate.