

Case Number:	CM14-0045226		
Date Assigned:	08/08/2014	Date of Injury:	07/20/1999
Decision Date:	10/02/2014	UR Denial Date:	03/20/2014
Priority:	Standard	Application Received:	04/14/2014

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 Emergency Medicine, has a subspecialty in Fellowship Trained in Emergency Medical Services and is licensed to practice Texas. 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 59-year-old female who reported an injury on 10/27/1997. The mechanism of injury was not provided for clinical review. Diagnoses include status post C6-7 anterior cervical discectomy and fusion with postlaminectomy neck pain, severe intractable headaches, bilateral upper extremity radicular pain, low back pain status post motor vehicle accident, anxiety and depression secondary to chronic pain syndrome. Previous treatments included medication, epidural steroid injections, and surgery. The diagnostic testing included an MRI. In the clinical note dated 03/03/2014, it was reported the injured worker complained of increasing neck pain, upper extremity radicular symptoms including pain, numbness, and weakness. The injured worker complained of severe headaches. The injured worker complained of numbness and tingling in both arms which radiated to the fingertips. The injured worker rated her pain 7/10 to 8/10 in severity with medication, and 10/10 in severity without medication. Upon the physical examination, the provider noted the injured worker had decreased range of motion with flexion at 10 degrees and extension at 0 degrees. The provider indicated the injured worker had bilateral paraspinal tenderness. The injured worker had 1+ acute muscle spasms in the cervical paraspinal muscles. The provider indicated the injured worker had a positive compression test for radicular symptoms in the left upper extremity. The provider requested trazodone, Topamax, Valium, omeprazole, Phenergan, Lexapro and baclofen. A rationale was not provided for clinical review. The Request for Authorization was submitted and dated on 03/17/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Trazadone 100mg, #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use, On-Going Management Page(s): 78.

Decision rationale: The California MTUS Guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The guidelines recommend the use of a urine drug screen or inpatient treatment with issues of abuse, addiction, or poor pain control. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. The provider failed to document an adequate and complete pain assessment within the physical examination. Additionally, the use of a urine drug screen was not provided for clinical review. Therefore, the request for Trazadone 100mg, #120 is not medically necessary.

Topamax 100mg, #360: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs) Page(s): 16-21.

Decision rationale: The California MTUS Guidelines recommend Topamax for neuropathic pain. The guidelines also note Topamax has been shown to have variable efficacy, with failure to demonstrate efficacy in neuropathic pain of central etiology. It is still considered for the use of neuropathic pain when other anticonvulsants fails. After initiation of the treatment, there should be documentation of pain relief and improvement of function, as well as documentation of side effects incurred with use. There was lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. There is lack of documentation indicating the injured worker was treated for or diagnosed with neuropathic pain. Therefore, the request for Topamax 100mg, #360 is not medically necessary.

Valium 10mg, #14 (3 Refills): Upheld

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

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

Decision rationale: The California MTUS Guidelines do not recommend Valium for long term use due its long term efficacy being unproven and there is risk of dependence. The guidelines also recommend the limited use of Valium to 4 weeks. The injured worker has been utilizing the medication since at least 03/2014, which exceeds the guidelines recommendation of short term use of 4 weeks. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. Therefore, the request for Valium 10 mg, #14 (3 Refills) is not medically necessary.

Omeprazole 20mg, #60 (3 Refills): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Pain Chapter, Proton Pump Inhibitors

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines GI symptoms & cardiovascular risk Page(s): 68-69.

Decision rationale: The California MTUS Guidelines note proton pump inhibitors such as omeprazole are recommended for injured workers at risk for gastrointestinal events and/or cardiovascular disease. The risk factors for gastrointestinal events include over the age of 65, a history of peptic ulcer, gastrointestinal bleed and/or perforation, use of corticosteroids and/or anticoagulants. In the absence of risk factors for gastrointestinal bleeding, proton pump inhibitors are indicated when taking NSAIDs. The treatment of dyspepsia from NSAID usage includes stopping the NSAID, switching to a different NSAID, or adding an H2 receptor antagonist or proton pump inhibitor. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. Additionally, there is lack of documentation indicating the injured worker had a diagnosis of dyspepsia secondary to NSAID therapy. Therefore, the request for Omeprazole 20mg, #60 (3 Refills) is not medically necessary.

Phenergan 25mg, #30 (3 Refills): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Chapter

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Phenergan

Decision rationale: The Official Disability Guidelines note short term usage of antiemetics to combat opioid induced nausea for a period of less than 4 weeks, the presence of long standing symptoms of nausea and vomiting do warrant the additional workup to evaluate the etiology of these symptoms. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. Additionally, there is lack of clinical documentation indicating the

injured worker is treated for nausea and vomiting. Therefore, the request for Phenergan 25 mg, #30 (3 Refills) is not medically necessary.

Lexapro 20mg, #30 (3 Refills): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Depressants for Chronic Pain.

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

Decision rationale: The California MTUS Guidelines recommend antidepressants as a first line option for neuropathic pain. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. Therefore, the request for Lexapro 20mg, #30 (3 Refills) is not medically necessary.

Baclofen 10mg, #60 (3 Refills): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63-64.

Decision rationale: The California MTUS Guidelines recommend non-sedating muscle relaxants with caution as a second line option for short term treatment of acute exacerbations in patients with chronic low back pain. The guidelines note the medication is not recommended to be used for longer than 2 to 3 weeks. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. Additionally, the injured worker has been utilizing the medication since at least 03/2014, which exceeds the guidelines recommendation of short term use of 2 to 3 weeks. Therefore, the request for Baclofen 10mg, #60 (3 Refills) is not medically necessary.