

Case Number:	CM14-0052967		
Date Assigned:	07/07/2014	Date of Injury:	05/10/2006
Decision Date:	08/21/2014	UR Denial Date:	03/21/2014
Priority:	Standard	Application Received:	04/21/2014

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, has a subspecialty in Pain Management 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:

This is a male patient with a date of injury of May 10, 2006. A utilization review determination dated March 20, 2014 recommend non-certification of Motrin 800 mg #60, Neurontin with modification to 300 mg #10 for process of weaning, Protonix 20 mg #60, 1 current potential threshold, and a follow-up visit. A progress note dated March 14, 2014 identifies subjective complaints of constant low back pain rated at a 5/10 with radiation to left lower extremity, constant cervical pain rated at a 7 - 8/10 with radiation to bilateral shoulders, bilateral shoulder pain, and headaches. Physical examination identifies tenderness and spasm in the cervical and trapezius region, Limited cervical spine range of motion with lateral rotation at 35, Limited lumbar spine range of motion with pain, tenderness of the lumbar spine, and positive straight leg raise. Diagnoses include brachial neuritis, lumbosacral neuritis, and adhesive capsulitis of the shoulder. The treatment plan recommends continuation of medications, Protonix 20 mg two times per day (b.i.d.) due to mild gastritis caused by Motrin, and a follow-up visit scheduled for June 13, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Motrin 800 mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-72.

Decision rationale: Regarding the request for Motrin 800mg #60, Chronic Pain Medical Treatment Guidelines state that NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Within the documentation available for review, there is no indication that Motrin is providing any specific analgesic benefits (in terms of percent pain reduction, or reduction in numeric rating scale), or any objective functional improvement. In the absence of such documentation, the currently requested Motrin 800mg #60 is not medically necessary.

Neurontin: Upheld

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

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

Decision rationale: Regarding the request for Neurontin, Chronic Pain Medical Treatment Guidelines state that antiepilepsy drugs (AEDs) are recommended for neuropathic pain. They go on to state that a good outcome is defined as 50% reduction in pain and a moderate response is defined as 30% reduction in pain. Guidelines go on to state that after initiation of treatment, there should be documentation of pain relief and improvement in function as well as documentation of side effects incurred with use. The continued use of AEDs depends on improved outcomes versus tolerability of adverse effects. Within the documentation available for review, there is no identification of any specific analgesic benefit (in terms of percent reduction in pain or reduction of NRS), and no documentation of specific objective functional improvement. Additionally, there is no discussion regarding side effects from this medication. In the absence of such documentation, the currently requested Neurontin is not medically necessary.

Protonix 20 mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Proton Pump Inhibitors Page(s): 68-69. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Proton Pump Inhibitors (PPIs).

Decision rationale: Regarding the request for Protonix 20mg #60, California MTUS states that proton pump inhibitors are appropriate for the treatment of dyspepsia secondary to NSAID therapy or for patients at risk for gastrointestinal events with NSAID use. Additionally, Official Disability Guidelines (ODG) recommends Nexium, Protonix, Dexilant, and AcipHex for use as second line agents, after failure of Omeprazole or Lansoprazole. Within the documentation available for review, there is no indication that the patient has a risk for gastrointestinal events

with NSAID use, or another indication for this medication. Furthermore, there is no indication that the patient has failed first-line agents prior to initiating treatment with Protonix (a second line proton pump inhibitor). In the absence of clarity regarding those issues, the currently requested Protonix 20mg #60 is not medically necessary.

One current potential threshold: 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).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee, Current Perception Threshold (CPT) testing.

Decision rationale: Regarding the request for current perception threshold (CPT) testing, California MTUS does not address the issue. Official Disability Guidelines (ODG) state CPT testing is not recommended. They go on to state that CPT testing is considered experimental or investigational, as there is inadequate scientific literature to support any conclusions regarding the effects of this testing on health outcomes. In light of the above issues, the currently requested current perception threshold (CPT) testing is not medically necessary.

Follow up visit: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain (Chronic).

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

Decision rationale: Regarding the request for a follow up visit, Official Disability Guidelines (ODG) state that office visits are recommended as determined to be medically necessary. Evaluation and management (E&M) outpatient visits to the offices of medical doctor(s) play a critical role in the proper diagnosis and return to function of an injured worker, and they should be encouraged. The need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The determination is also based on what medications the patient is taking, since some medicines such as opiates, or medicines such as certain antibiotics, require close monitoring. As patient conditions are extremely varied, a set number of office visits per condition cannot be reasonably established. Within the documentation available for review, a three-month follow-up visit was requested. This request is reasonable, given that the patient appears to have unresolved complaints of low back pain, neck pain, and shoulder pain. As such, the currently requested follow up visit is medically necessary.