

<b>Case Number:</b>	CM14-0056933		
<b>Date Assigned:</b>	07/09/2014	<b>Date of Injury:</b>	03/17/1998
<b>Decision Date:</b>	09/17/2014	<b>UR Denial Date:</b>	04/04/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/28/2014

### 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 & Rehabilitation and Pain Medicine, and is licensed to practice in Texas and Ohio. 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 55-year-old female who reported an injury on 03/17/1998. The mechanism of injury was not provided for clinical review. The diagnoses included post cervical post laminectomy syndrome, tarsal tunnel syndrome, carpal tunnel syndrome bilaterally status post 3 surgeries, rotator cuff disorders status post-surgery on the left side, neck pain, headache, cervical discectomy, and lumbar fusion times 2. The previous treatments included medication and surgeries. Within the clinical note dated 02/03/2014, it was reported the injured worker complained of neck and upper extremity pain. She reported having increased pain on the right side of the neck with radiation down into the right arm. Upon the physical examination, the provider noted the injured worker to be alert and oriented. She noted the injured worker ambulated to the examination room without assistance. The provider noted the injured worker had benefited from a radiofrequency ablation. The provider requested Cymbalta, Celebrex, Opana, hydrocodone, Protonix. However, a rationale was not provided for clinical review. The Request for Authorization was not provided for clinical review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Cymbalta 60 MG # 30 5 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Depressants Page(s): 15.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Depressants for Chronic Pain Page(s): 13, 15.

**Decision rationale:** The request for Cymbalta 60 mg #30 with 5 refills is not medically necessary. The California MTUS Guidelines recommend antidepressants as a first line option for neuropathic pain. The guidelines note Cymbalta is FDA approved for anxiety, depression, diabetic neuropathy, and fibromyalgia. 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 is not medically necessary.

**Celebrex 200 MG # 30, 5 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-inflammatory medications Page(s): 22.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (Non-Steroidal Anti-Inflammatory Drugs) Page(s): 66-67.

**Decision rationale:** The request for Celebrex 200 mg #30 with 5 refills is not medically necessary. The California MTUS Guidelines recommend Non-Steroidal Anti-Inflammatory Drugs at the lowest dose for the shortest period of time. The guidelines note NSAIDs are recommended for the signs and symptoms of osteoarthritis. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The injured worker has been utilizing the medication since at least 02/2014. Additionally, the request submitted failed to provide the frequency of the medication. Therefore, the request is not medically necessary.

**Opana ER 20 MG # 90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74.

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

**Decision rationale:** The request for Opana ER 20 mg #90 is not medically necessary. 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. Additionally, the use of a urine drug screen was not provided for clinical review. Therefore, the request is not medically necessary.

**Hydrocodone 10/325 MG # 180:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78.

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

**Decision rationale:** The request for Hydrocodone 10/325 mg #180 is not medically necessary. 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 frequency of the medication. Additionally, the use of a urine drug screen was not provided for clinical review. The injured worker has been utilizing the medication since at least 02/2014. Therefore, the request is not medically necessary.

**Protonix DR 40 MG # 30 5 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Inflammatory Medications Page(s): 68.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 68-69.

**Decision rationale:** The request for Protonix DR 40 mg #30 with 5 refills is not medically necessary. The California MTUS Guidelines note Proton Pump Inhibitors, such as Prilosec, 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; history of peptic ulcer, gastrointestinal bleeding, or perforation; use of corticosteroids and/or anticoagulants. In the absence of risk factors for gastrointestinal bleeding, proton pump inhibitor are not indicated when taking NSAIDs. The treatment of dyspepsia from NSAID usage includes stopping the NSAID, switching to a different NSAID, 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. There is a lack of documentation indicating the injured worker had a history of peptic ulcer, gastrointestinal bleeding, or perforation. Additionally, there is lack of clinical documentation indicating the injured worker had a diagnosis of dyspepsia secondary to NSAID therapy. Therefore, the request is not medically necessary.