MAXIMUS Federal Services

| Case Number: | CM14-0074075 | | |
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| Date Assigned: | 08/04/2014 | Date of Injury: | 07/23/2008 |
| Decision Date: | 09/26/2014 | UR Denial Date: | 05/02/2014 |
| Priority: | Standard | Application Received: | 05/21/2014 |

## 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 Family 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 injured worker is a 51 year old female who had a work related injury on 07/23/08. The mechanism of injury is undisclosed. Most recent clinical documentation submitted for review was dated 04/29/14, the injured worker complained of right shoulder pain progressively getting worse, described as a sharp pain unable to reach back, and could not comb her hair, having difficulty with activities of daily living. Physical examination of cervical spine revealed flexion to 50 degrees, extension to 60 degrees, right rotation 65 degrees, left rotation 65 degrees, tenderness and spasm at the cervical paraspinal musculature, and right shoulder revealed decreased range of motion. Diagnoses are listed at chronic pain syndrome, disc herniation with radiculitis and radiculopathy in the cervical spine, right elbow lateral epicondylitis, right shoulder tendinitis/impingement/bilateral wrist tendinitis/carpal tunnel syndrome, lumbar spine disc herniation with radiculopathy, right knee internal derangement. Prior utilization review on 05/02/14 was noncertified. Current request was for Anaprox 550 milligrams refill, Remeron refill, Prilosec 20 milligrams refill, and chiropractic two times a week for four weeks. In reviewing the limited clinical records that were submitted, there was no clinical documentation why the patient would be on Remeron, there was no indication that the patient had GI problems or was at risk of developing them. There was no clinical documentation that she responded to Anaprox. Prior utilization review, requests were noncertified.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Anaprox 550mg refill:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20, NSAIDs, specific drug list & adverse effects, page(s) 70 Page(s): 70.

**Decision rationale:** As noted in the Chronic Pain Medical Treatment Guidelines, nonsteroidal anti-inflammatory drugs (NSAIDs) are recommended as a second line treatment after acetaminophen for acute exacerbations of chronic pain. In general, there is conflicting evidence that NSAIDs are more effective than Acetaminophen for acute lower back pain. Package inserts for NSAIDs recommend periodic lab monitoring of a complete blood count (CBC) and chemistry profile (including liver and renal function tests). There is no documentation that these monitoring recommendations have been performed and the patient is being monitored on a routine basis. Additionally, it is generally recommended that the lowest effective dose be used for all NSAIDs for the shortest duration of time. As such, the request for this medication cannot be established as medically necessary.

**Remeron refill.:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain Page(s): page(s) 13-16.

**Decision rationale:** The request for Remeron refill is not medically necessary. The clinical documentation submitted for review does not support the request. There is no reason documented on why the patient is on Remeron. Therefore medical necessity has not been established.

**Prilosec 20mg refill.:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines - online version Integrated Treatment/Disability Duration Guidelines, Chronic Pain, Proton pump inhibitors (PPIs).

**Decision rationale:** As noted in the Official Disability Guidelines, proton pump inhibitors (PPIs) are indicated for patients at intermediate and high risk for gastrointestinal events with concurrent use of nonsteroidal anti-inflammatory drug use. Risk factors for gastrointestinal (GI) events include age greater than 65 years; history of peptic ulcer, GI bleeding or perforation; concurrent use of Aspirin (ASA), corticosteroids, and/or an anticoagulant; or high dose/multiple NSAID (e.g., NSAID plus low dose Aspirin). There is no indication that the patient is at risk for gastrointestinal events requiring the use of proton pump inhibitors. Furthermore, long term PPI

use (greater than one year) has been shown to increase the risk of hip fracture. As such, the request for this medication cannot be established as medically necessary.

**Chiropractic 2 times a week for four weeks:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173.

**Decision rationale:** The request for chiropractic two times a week for four weeks is not medically necessary. The clinical documentation does not support the request. There is no documentation submitted explaining the need for chiropractic treatment, therefore, medically necessity has not been established.