MAXIMUS Federal Services

Case Number:	CM14-0087111		
Date Assigned:	07/23/2014	Date of Injury:	04/14/1999
Decision Date:	09/17/2014	UR Denial Date:	05/14/2014
Priority:	Standard	Application Received:	06/10/2014

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 Internal medicine and is licensed to practice in Maryland. 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 employee was a 47-year old female who sustained an industrial injury on 04/14/1998. Her diagnoses included complex regional pain syndrome with weakness and contracture of the left upper and lower extremities. Her medications included Flexeril, Lidocaine patches, lidocaine ointment, Zofran, Ambien, Norco, Oxycontin, Ibuprofen and Prevacid. The visit notes were reviewed from 05/07/14. Subjective complaints included neck and low back pain at 5-6/10. She was having limitations with most of her activities. She reported that on 02/28/14, her cane was caught in the wind causing her to land on her left knee. She also fell on her back. She subsequently developed pain in her left knee and swelling in her knee cap. She was using cervical stimulator on a regular basis for the CRPS. Her medications included Flexeril, Prevacid, Lidocaine patches, Lidocaine ointment, Zofran, Ambien, Norco, Oxycontin and Ibuprofen. Prevacid was being used for gastritis. Her pain decreased from 9/10 to 6-7/10 with medications. The CURES report was consistent with current treatment and there was no aberrant behavior. Pertinent objective examination included antalgic gait, tenderness to palpation of cervical, thoracic and lumbar spines and contracture with weakness of left upper and lower extremities. Diagnoses included late stage complex regional pain syndrome, status post spinal cord stimulator implant and generator site pain. The plan of care included CT scan of cervical, thoracic and lumbar spines and continuation of medications including Flexeril, Ibuprofen 800mg PO TID PRN, Oxycontin 30mg PO BID, Norco PO TID PRN and Prevacid 30mg daily. During her prior visit in March 2014, an Internal medicine consultation was requested for GI problems.

IMR ISSUES, DECISIONS AND RATIONALES

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

Prevacid 30mg #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI symptoms and cardiovascular risk Page(s): 58-59, 68-69.

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines, patients with intermediate and high risk for GI events should be treated with medications like proton pump inhibitors. Such risk factors include an age over 65 years, history of peptic ulcer disease, GI bleeding or perforation, concurrent use of aspirin, steroids and anticoagulants and use of high dose or multiple NSAIDs. The guidelines also recommend for the treatment of dyspepsia secondary to NSAID therapy, to stop the NSAID, switch to a different NSAID or consider H2-receptor antagonist or a PPI. The employee was a 47 year old female who was being treated for complex regional pain syndrome with contractures of left upper and lower extremties following an injury in 1998. She was being treated with Opiates, Flexeril and Ibuprofen. She also was being treated with Prevacid for GI symptoms. But the progress notes provided for review didn't have any GI symptoms listed. There is also no documentation of relevant diagnoses of dyspepsia, concurrent use of anticoagulants or aspirin or prior history of peptic ulcer disease or GI bleeding. Hence the request for Prevacid is not medically necessary or appropriate without additional documentation.