

Case Number:	CM14-0186823		
Date Assigned:	11/14/2014	Date of Injury:	02/28/2011
Decision Date:	01/05/2015	UR Denial Date:	10/24/2014
Priority:	Standard	Application Received:	11/10/2014

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 Preventative (Occupational) Medicine and is licensed to practice in Massachusetts, New Hampshire and New York. 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 male who reported an injury on 02/28/2011. The mechanism of injury was not submitted for clinical review. The diagnoses included major depressive disorder, insomnia disorder due to pain, psychological factor affecting medical condition, cervicgia, and lumbosacral neuritis. Previous treatments included medication. Within the clinical note dated 10/20/2014, it was reported that the injured worker complained of cervical spine pain which was aggravated by repetitive motion of the neck, pushing, pulling, lifting, forward reaching, and working above the shoulder level. He described the pain as sharp. He rated his pain 4/10 in severity. The injured worker complained low back pain which he rated 8/10 in severity. The physical examination revealed paravertebral muscle tenderness with spasms. The range of motion of the cervical spine was limited by pain. The lumbar spine had palpable paravertebral muscle tenderness with spasms. Flexion and extension were guarded and restricted. The injured worker had tingling and numbness in the lateral thigh, anterolateral and posterior leg, as well as the foot, in an L5-S1 dermatomal pattern. The request was submitted for omeprazole DR, cyclobenzaprine HCL, naproxen sodium, and tramadol ER. However, a rationale was not submitted for clinical review. The Request for Authorization was not submitted for clinical review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Omeprazole DR 20mg #120 DOS: 9/11/13: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs GI Symptoms & Cardiovascular Risk.

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

Decision rationale: The request for Omeprazole DR 20mg #120 DOS: 9/11/13 is not medically necessary. The California MTUS Guidelines note that 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, history of peptic ulcer, gastrointestinal bleed or perforation. In the absence of risk factors for gastrointestinal bleeding events, proton pump inhibitors are not 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 a lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. There is a lack of documentation indicating the injured worker had a diagnosis of dyspepsia secondary to NSAID therapy. Additionally, the date of service for the requested medication was not submitted for clinical review. The request submitted failed to provide the frequency of the medication. Therefore, the request is not medically necessary.

Cyclobenzaprine HCL 7.5 mg #120 9/11/13: 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 request for Cyclobenzaprine HCL 7.5 mg #120 9/11/13 is not medically necessary. The California MTUS Guidelines recommend nonsedating 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 that the medication is not recommended to be used for longer than 2 to 3 weeks. There is a 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 date of service for the requested medication was not submitted for clinical review. Therefore, the request is not medically necessary.

Naproxen Sodium 550 mg #100 DOS: 9/11/13: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Naproxen, Page(s): 66-67.

Decision rationale: The request for Naproxen Sodium 550 mg #100 DOS: 9/11/13 is not medically necessary. The California MTUS Guidelines note naproxen is nonsteroidal anti-inflammatory drug for the relief of the signs and symptoms of osteoarthritis. The guidelines recommend naproxen at the lowest dose for the shortest period of time in patients with moderate to severe pain. There is a 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 date of service for the requested medication was not submitted for clinical review. As such, the request is not medically necessary.

Tramadol ER 150mg #90 DOS: 9/11/13: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use, On-Going Management Page(s): 77-78.

Decision rationale: The request for Tramadol ER 150 mg #90 DOS: 9/11/13 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 a 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 provider failed to document an adequate and complete pain assessment within the documentation. The date of service for the requested medication was not submitted for clinical review. Therefore the request is not medically necessary.