

Case Number:	CM14-0205996		
Date Assigned:	12/18/2014	Date of Injury:	10/30/2013
Decision Date:	02/06/2015	UR Denial Date:	12/08/2014
Priority:	Standard	Application Received:	12/09/2014

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 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 patient is a 57 year old female substitute teacher with a date of injury of 10/30/2012. She fell backwards 4 stairs and hit her neck, back and the back of her head. She had a loss of consciousness. She had a motor vehicle accident in 1985 and was comatose for 59 days. In 2006 she had another MVA and had a right shoulder injury. She has neck and back pain. On 04/29/2013 she had a slip and fall injury at home. On 11/21/2013 a MRI of her brain revealed multiple infarcts that were old. No acute changes were noted. There was no mass effect. On 12/11/2013 she had decreased cervical and lumbar range of motion. She had a moderate ataxic gait. Motor strength was 5/5. She had decreased sensation to pain and temperature at C5-C6. Babinski was normal. EEG was normal. On 03/19/2014 she had dizziness, headache, back pain and neck pain. Motor strength was normal. Babinski was negative. Reflexes were normal. EMG was normal and NCS revealed mild right carpal tunnel syndrome. On 06/17/2014 she had decreased cervical and lumbar range of motion. She was alert and oriented. Intelligence, judgment, insight, reading, language skills, articulation and writing were all normal. Cerebellar function was normal. Gait was unsteady. On 08/13/2014 she had an antalgic gait. During 03/19/2014, 06/17/2014 and 08/13/2014 she had decreased sensation to pain and temperature bilaterally at C5-C6,L5 and S2. On 12/18/2014 the patient had headache, neck pain and back pain. Vital signs were normal. She had decreased range of motion of her neck, back and right ankle. Mental status was normal. Cerebellar function was normal. Cranial nerves were intact. She had a moderate antalgic gait. There was decreased sensation to pain and temperature bilaterally at C5-C6, L5 and S2. Motor strength was 1+/5 bilaterally at C5-C6 and L5-S1.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lyrica 75 MG #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pregabalin (Lyrica) Page(s): 99.

Decision rationale: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES Chronic Pain Medical Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page 99. Pregabalin (Lyrica) Pregabalin (Lyrica) has been documented to be effective in treatment of diabetic neuropathy and postherpetic neuralgia, has FDA approval for both indications, and is considered first-line treatment for both. Pregabalin was also approved to treat fibromyalgia. There is no documentation of diabetic neuropathy or post herpetic neuralgia. She does not have fibromyalgia. She does have documentation of multiple cerebral infarcts and this is not treated with Lyrica. Treatment with Lyrica is not consistent with MTUS guidelines.

Naproxen Sodium 550 MG #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS. Page(s): 67 - 68.

Decision rationale: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES Chronic Pain Medical Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page 67. NSAIDs (non-steroidal anti-inflammatory drugs) Specific recommendations: Osteoarthritis (including knee and hip): Recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Acetaminophen may be considered for initial therapy for patients with mild to moderate pain, and in particular, for those with gastrointestinal, cardiovascular or renovascular risk factors. NSAIDs appear to be superior to acetaminophen, particularly for patients with moderate to severe pain. There is no evidence to recommend one drug in this class over another based on efficacy. In particular, there appears to be no difference between traditional NSAIDs and COX-2 NSAIDs in terms of pain relief. The main concern of selection is based on adverse effects. COX-2 NSAIDs have fewer GI side effects at the risk of increased cardiovascular side effects, although the FDA has concluded that long-term clinical trials are best interpreted to suggest that cardiovascular risk occurs with all NSAIDs and is a class effect (with naproxyn being the safest drug). There is no evidence of long-term effectiveness for pain or function. (Chen, 2008) (Laine, 2008) Back Pain - Acute exacerbations of chronic pain: Recommended as a second-line treatment after acetaminophen. In general, there is conflicting evidence that NSAIDs are more effective than acetaminophen for acute LBP. (van Tulder, 2006) (Hancock, 2007). As noted on page 68 for chronic back pain only short term use of NSAIDS is recommended. Long term treatment with NSAIDS is not consistent with MTUS guidelines.

Omeprazole Dr 20 MG #30 with 2 Refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS GI Symptoms and Cardiovascular Risk. Page(s): 68.

Decision rationale: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES Chronic Pain Medical Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page 68. NSAIDs, GI symptoms & cardiovascular risk Recommend with precautions as indicated below. Clinicians should weight the indications for NSAIDs against both GI and cardiovascular risk factors. Determine if the patient is at risk for gastrointestinal events: (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA). Recent studies tend to show that H. Pylori does not act synergistically with NSAIDS to develop gastroduodenal lesions. Recommendations Patients with no risk factor and no cardiovascular disease: Non-selective NSAIDs OK (e.g., ibuprofen, naproxen, etc.) Patients at intermediate risk for gastrointestinal events and no cardiovascular disease: (1) A non-selective NSAID with either a PPI (Proton Pump Inhibitor, for example, 20 mg omeprazole daily) or misoprostol (200 g four times daily) or (2) a Cox-2 selective agent. Long-term PPI use (> 1 year) has been shown to increase the risk of hip fracture (adjusted odds ratio 1.44). Patients at high risk for gastrointestinal events with no cardiovascular disease: A Cox-2 selective agent plus a PPI if absolutely necessary. Patients at high risk of gastrointestinal events with cardiovascular disease: If GI risk is high the suggestion is for a low-dose Cox-2 plus low dose Aspirin (for cardioprotection) and a PPI. There is no documentation of peptic ulcer disease, gastritis, GI bleeding and the patient is less than 65 years of age. She does not meet MTUS criteria for a PPI.