

Case Number:	CM15-0106575		
Date Assigned:	06/10/2015	Date of Injury:	02/10/2009
Decision Date:	07/21/2015	UR Denial Date:	05/05/2015
Priority:	Standard	Application Received:	06/02/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: New York
 Certification(s)/Specialty: Anesthesiology

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 46 year old female who sustained a work related injury February 10, 2009. According to a pain medicine re-evaluation, dated April 8, 2015, the injured worker presented with neck pain which radiates down the right upper extremity with muscle weakness and bilateral occipital headaches. There are complaints of upper extremity pain in the bilateral elbows. Her pain is rated 9/10 with medication and 10/10 without medication. She also reports GERD (gastroesophageal reflux disease) related medication associated gastrointestinal upset. She is s/p cervical epidural injection bilateral C5-6 9/30/2014, with a 50-80% overall improvement for 3 months. Physical examination of the cervical spine revealed; bilateral spasm in the paraspinal muscles and tenderness on palpation bilateral C5-7 and bilateral occipital regions, range of motion limited due to pain, sensation decreased in the right upper extremity with the affected dermatome C6 and decreased grip strength on the right. The lumbar spine revealed; tenderness on palpation in the bilateral paravertebral L4-S1 with spasm. There is tenderness noted in the right elbow with moderate swelling. Range of motion decreased due to pain. Diagnoses are chronic pain, other; cervical disc degeneration; cervical radiculopathy; right elbow pain, occipital neuralgia; right-sided lateral epicondylitis; ulnar neuritis. At issue, is the request for authorization for Compazine, Flexeril, Floricet, Naproxen, Omeprazole DR, and Percocet.

IMR ISSUES, DECISIONS AND RATIONALES

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

Compazine 10mg #60: 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 UpToDate.

Decision rationale: Prochlorperazine (Compazine) is a dopamine receptor antagonist that belongs to the phenothiazine class of antipsychotic agents. It is used for the treatment of nausea and vomiting. It is also a highly potent typical antipsychotic. In this case, there is no documentation of nausea and vomiting. The medication is not indicated for treatment of chronic pain or neuromuscular conditions. Medical necessity for the requested medication has not been established. The requested medication is not medically necessary.

Naproxen sodium 550mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-71. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) NSAIDs.

Decision rationale: Naproxen is a non-steroidal anti-inflammatory drug (NSAID). Oral NSAIDs are recommended for the treatment of chronic pain and control of inflammation as a second-line therapy after acetaminophen. The ODG states that NSAIDs are recommended for acute pain, osteoarthritis, acute low back pain (LBP) and acute exacerbations of chronic pain, and short-term pain relief in chronic LBP. There is no evidence of long-term effectiveness for pain or function. There is inconsistent evidence for the use of NSAIDs to treat long-term neuropathic pain. Guidelines recommended that the lowest effective dose be used for the shortest duration of time consistent with treatment goals. In this case, the patient had prior use of NSAIDs without any documentation of significant improvement. There was no documentation of subjective or objective benefit from use of this medication. Medical necessity of the requested medication has not been established. The request for Naproxen is not medically necessary.

Floriset 50/325/40mg #30: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation UpToDate.

Decision rationale: Barbiturate-containing analgesic agents (BCAs) are not recommended for chronic pain. The potential for drug dependence is high and no evidence exists to show a clinically important enhancement of analgesic efficacy of BCAs due to the barbiturate constituents. Fioricet contains butalbital, tylenol, and caffeine. The literature reported that butalbital containing combination analgesics should be avoided in migraine headache management. When used, it should be closely monitored to avoid overuse and dependence. It is recommended to be used less than 10 days/month. In this case, there is no documentation of the efficacy of this medication. Medical necessity for the requested item has not been established. The requested item is not medically necessary.

Flexeril 10mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Flexeril (Cyclobenzaprine).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63.

Decision rationale: According to the reviewed literature, Cyclobenzaprine (Flexeril) is not recommended for the long-term treatment of chronic pain. This medication has its greatest effect in the first four days of treatment. Guidelines state that this medication is not recommended to be used for longer than 2-3 weeks. According to CA MTUS Guidelines, muscle relaxants are not considered any more effective than non-steroidal anti-inflammatory medications alone. In this case, there are muscle spasms documented on physical exam. However, there is no documentation of functional improvement from any previous use of this medication. Based on the currently available information, the medical necessity for this muscle relaxant has not been established. The requested medication is not medically necessary.

Omeprazole DR 20mg #30: 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 PPIs Page(s): 68. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) PPIs.

Decision rationale: According to the California MTUS (2009), Omeprazole (Prilosec), is proton pump inhibitor (PPI) that is recommended for patients taking NSAIDs, with documented GI distress symptoms, or at risk for gastrointestinal events. GI risk factors include: age >65, history of peptic ulcer, GI bleeding, or perforation; concurrent use of aspirin, corticosteroids, and/or anticoagulants, or high dose/multiple NSAIDs. PPIs are highly effective for their approved indications, including preventing gastric ulcers induced by NSAIDs. There is documentation indicating that this patient has GERD. The medication has proved beneficial in the treatment of this condition. The medical necessity for Omeprazole has not been established. The requested medication is not medically necessary.

Percocet 5/325mg #180: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of Opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for the treatment of chronic pain Page(s): 91-97. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Opioids.

Decision rationale: According to the CA MTUS and the ODG, Percocet (Oxycodone / Acetaminophen) is a short-acting opioid analgesic indicated for moderate to severe pain, and is used to manage both acute and chronic pain. The treatment of chronic pain with any opioid analgesic requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. A pain assessment should include current pain, intensity of pain after taking the opiate, and the duration of pain relief. In this case, there is no documentation of the medication's pain relief effectiveness, functional status, or response to ongoing opioid analgesic therapy. Medical necessity of the requested medication has not been established. Of note, discontinuation of an opioid analgesic should include a taper, to avoid withdrawal symptoms. The requested treatment with Percocet 5/325 mg is not medically necessary.