

Case Number:	CM15-0180236		
Date Assigned:	09/22/2015	Date of Injury:	11/09/2006
Decision Date:	10/30/2015	UR Denial Date:	09/01/2015
Priority:	Standard	Application Received:	09/14/2015

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: California, Hawaii

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 57 year old male, who sustained an industrial injury on 11-9-06. The documentation on 8-18-15 noted that the injured worker has complaints of pain in his neck, left shoulder and low back with experiencing a flare up of his back pain for the past week after vacuuming and performing household chores. The injured workers pain level is rated as a 5-7 out of 10 in intensity but is reduced to a 2-3 out of 10 with use of his medications. There is tenderness and guarding in the cervical paraspinal musculature and range of motion of the cervical spine is decreased secondary to pain. Examination of the bilateral upper extremities demonstrates no focal atrophy, tremor, fasciculation or ataxia and there is no evidence of clonus or spasticity in the upper extremities. Lumbar spine examination revealed there is tenderness and guarding in the lumbar paraspinal musculature and range of motion is decreased secondary to pain. Examination of the bilateral lower extremities demonstrates no focal atrophy, tremor, fasciculation or ataxia and no evidence of clonus or spasticity in the lower extremities. The documentation noted that the injured workers recent urine drug screen was consistent. Magnetic resonance imaging (MRI) of the cervical spine on 7-9-12 revealed posterior disc bulges of 3 millimeter at C6-7, 3 to 4 millimeter at C2-3 and C4-5, 4 millimeter at C7-T1 and 4 to 5 millimeter at C3-4 as well as a 5 to 6 millimeter disc protrusion at C5-6 with central canal narrowing that is mild at both C4-5 and C6-7 and moderate at both C5-6 and C7-T1. Magnetic resonance imaging (MRI) of the lumbar spine on 1-10-14 revealed anterior and posterior interbody fusion at L3-4 and L4-5 with anterior plate and screw fixation present and posterior decompression is noted at L4. Magnetic resonance imaging (MRI) of the left shoulder on 10-16-

14 showed high grade near full thickness articular sided and intrasubstance tearing of the supraspinatus an infraspinatus; subscapularis intact and moderate fatty infiltration of the teres minor suggesting denervation. Lumbar spine X-ray on 5-19-15 revealed prior fusion with hardware extending from L3 to L5, with the injured worker having undergone an anterior-posterior fusion; there appears to be good consolidation of the fusion at the L3-4 and L4-5 segments; there is significant sclerosis of the facet joints at L5-S1 (sacroiliac) bilaterally and incidental note is made of significant metal fragments in the abdomen and pelvis. Cervical spine X-rays on 5-19-15 revealed straightening of the cervical lordosis; there is spondylosis at C4-5 with anterolisthesis of C4 on C5 on flexion that reduces with extension; there are extensive degenerative changes at C4-5 and C5-6; C6-7 cannot be seen because of high-riding shoulders and a short cervical spine and there are significant bone spurs at the C5-6 level and, to a lesser degree, at the C4-5 segment. The diagnoses have included displacement of cervical intervertebral disc without myelopathy; right shoulder impingement, including partial tear of the rotator cuff tendon; intractable pain and degeneration of cervical intervertebral disc. Treatment to date has included physical therapy; chiropractic session seemed to make his pain worse; acupuncture he had brief relief of his back pain and better control of his left knee pain; left knee surgery times three; right fourth trigger finger release; left index finger release; right shoulder surgery; left shoulder surgery; bilateral arthroscopic carpal tunnel releases and a lumbar fusion. The documentation on 8-18-15 noted that the injured workers medication was cyclobenzaprine; docusate sodium; norco; ranitidine; neurontin; atorvastatin; dulera; finasteride and naproxen sodium. The documentation noted that the injured workers work history is that he is permanent and stationary with regard to his lumbar spine, left knee and both shoulders and receiving treatment under his provisions for future medical care and he is also permanent and stationary with regard to his neck. The original utilization review (9-1-15) modified the request for ranitidine 150mg #30 with 3 refills to ranitidine 150mg #30 with no refills. The request for neurontin 300mg #30 with 3 refills has been modified to neurontin 300mg #30 with no refills.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ranitidine 150mg #30 with 3 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk.

Decision rationale: The patient presents with neck, left shoulder and low back pain. The current request is for Ranitidine 150mg #30 with 3 refills. The treating physician's report dated 08/18/2015 (81B) states, "He shares that he has been experiencing a flare up of his back pain for the past week after vacuuming and performing household chore. He is slowly returning to his baseline with use of his medications. His pain level is rated as 5-7/10 in intensity, but is reduced to a 2-3/10 with use of his medication." The MTUS Guidelines page 68 and 69 on NSAIDs, GI symptoms, and cardiovascular risks states, "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." MTUS also states, "Treatment of dyspepsia secondary to NSAID therapy: Stop the NSAID, switch to a different NSAID, or consider H2- receptor antagonists or a PPI." Medical records show that the patient was prescribed Ranitidine since before 05/20/15. None of the reports note gastrointestinal issues or events. The physician does not discuss a history of peptic ulcer disease, G.I. bleeding or perforation. He does not have a concurrent use of ASA or a corticosteroid and or anticoagulant. He is currently not on high- dose multiple NSAIDs. In this case, the routine use of PPI's is not supported by the MTUS guidelines. The current request is not medically necessary.

Neurontin 300mg #30 with 3 refills: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antiepilepsy drugs (AEDs).

Decision rationale: The patient presents with neck, left shoulder and low back pain. The current request is for Neurontin 300mg #30 with 3 refills. The treating physician's report dated 08/18/2015 (81B) states, "He shares that he has been experiencing a flare up of his back pain for the past week after vacuuming and performing household chore. He is slowly returning to his baseline with use of his medications. His pain level is rated as 5-7/10 in intensity, but is reduced to a 2-3/10 with use of his medication." The MTUS Guidelines pages 18 and 19 on gabapentin states that it has been shown to be effective for treatment of diabetic painful neuropathy and post-herpetic neuralgia, and has been considered as first-line treatment for neuropathic pain. MTUS page 60 states that for medications used for chronic pain, efficacy in terms of pain reduction and functional gains must also be documented. Medical records show that the patient was prescribed Neurontin prior to 08/20/15. Diagnoses include: disc bulges with central and foraminal stenosis, disc space collapse, lumbar fusion, left shoulder arthroscopy and decompression, right shoulder impingement, bilateral carpal tunnel release, left trigger finger release, and 3 left knee arthroscopy. In this case, the physician has noted medication efficacy as it relates to the use of Neurontin. The current request is medically necessary.