

Case Number:	CM15-0183045		
Date Assigned:	09/23/2015	Date of Injury:	03/11/1994
Decision Date:	10/28/2015	UR Denial Date:	08/25/2015
Priority:	Standard	Application Received:	09/17/2015

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: Arizona, California

Certification(s)/Specialty: Family Practice

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 69 year old male, who sustained an industrial injury on 3-11-1994. Medical records indicate the worker is undergoing treatment for lumbar radiculopathy and spondylolisthesis and left knee osteoarthritis. A recent progress report dated 8-13-2015, reported the injured worker complained of low back pain and left knee pain. Physical examination revealed lumbar flexion to 40 degrees and extension of 20 degrees cause low back pain, lumbosacral tenderness and left hip higher than right with right sided myofascial spasm. Treatment to date has included physical therapy and medication management. On 8-18-2015, the Request for Authorization requested new prescriptions for Anaprox 550mg #60 and Protonix 20mg #60 and a refill of Percocet 10-325mg #60 (since at least 2-26-2015). On 8-25-2015, the Utilization Review noncertified the request for Anaprox 550mg #60, Protonix 20mg #60 and Percocet 10-325mg #60.

IMR ISSUES, DECISIONS AND RATIONALES

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

Anaprox 550mg #60: 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 (non-steroidal anti-inflammatory drugs).

Decision rationale: According to the guidelines, NSAIDs are recommended as a second-line treatment after acetaminophen. Acetaminophen may be considered for initial therapy for patients with mild to moderate pain. NSAIDs are recommended as an option for short-term symptomatic relief. In this case, the claimant had been on NSAIDs for several months and required a proton pump inhibitor for gastric protection. There was no indication of Tylenol failure. Long-term NSAID use has renal and GI risks. Continued use of Anaprox is not medically necessary.

Protonix 20mg #60: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: According to the MTUS guidelines, Protonix is a proton pump inhibitor that is to be used with NSAIDs for those with high risk of GI events such as bleeding, perforation, and concurrent anticoagulation/anti-platelet use. In this case, there is no documentation of GI events or antiplatelet use that would place the claimant at risk. In addition, the long-term use of Anaprox as noted above is not necessary. Therefore, the continued use of Protonix is not medically necessary.

Percocet 10/325 #60: 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): Opioids for chronic pain, Opioids for neuropathic pain, Opioids, specific drug list.

Decision rationale: Percocet is a short acting opioid used for breakthrough pain. According to the MTUS guidelines, it is not indicated as 1st line therapy for neuropathic pain, and chronic back pain. It is not indicated for mechanical or compressive etiologies. It is recommended for a trial basis for short-term use. Long Term-use has not been supported by any trials. In this case, the claimant had been on Percocet for a year without significant improvement in pain or function several months in combination with NSAIDS. There was no mention of Tylenol or weaning failure. The continued and chronic use of short-acting opioids such as Percocet is not medically necessary.