

Case Number:	CM15-0187720		
Date Assigned:	09/29/2015	Date of Injury:	12/17/2009
Decision Date:	12/09/2015	UR Denial Date:	08/25/2015
Priority:	Standard	Application Received:	09/24/2015

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: Georgia

Certification(s)/Specialty: Anesthesiology, Pain Management

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This 43 year old male sustained an industrial injury on 12-17-09. Documentation indicated that the injured worker was receiving treatment for lumbar facet arthropathy, lumbar spine radiculopathy, left shoulder pain and chronic pain. Previous treatment included left shoulder surgery x 2, physical therapy, chiropractic therapy, acupuncture, injections and medications. In a pain management reevaluation dated 12-11-14, the injured worker complained of neck and low back pain rated 8 to 9 out of 10 on the visual analog scale without medications and 7 out of 10 with medications. The injured worker also reported having gastroesophageal reflux disease with medication associated gastrointestinal upset and sleep disruptions due to pain. The treatment plan included continuing medications Norco, Omeprazole, Tizanidine and Ibuprofen. In PR-2's dated 2-5-15, 3-6-15, 4-3-15 and 5-1-15, the injured worker reported that his pain was 7 to 8 out of 10 without medications and 6 to 7 out of 10 with medications. In a pain management progress note dated 7-9-15, the injured worker complained of worsening cervical spine pain with limited range of motion associated with numbness and tingling and worsening pain in the sacroiliac joints. The injured worker was prescribed Norco and Ambien. In a pain medicine reevaluation dated 7-24-15, the injured worker complained of neck pain with radiation down bilateral upper extremities associated with numbness and low back pain and spasms with radiation to bilateral lower extremities associated with numbness. The injured worker rated his pain 7 out of 10 on the visual analog scale without medications and 6 out of 10 with medications. The injured worker also reported having gastroesophageal reflux disease with medication associated gastrointestinal upset and sleep disruptions due to pain. Physical exam was remarkable for

lumbar spine with tenderness to palpation at L4-S1 with "moderately limited" range of motion secondary to pain, positive straight leg raise and "no changes" to sensory or lower extremity strength and left shoulder with tenderness to palpation, "decreased" range of motion due to pain and "decreased" strength to the left upper extremity. The injured worker received a Toradol injection during the office visit. The treatment plan included planning to attempt weaning Norco at the next office visit, continuing current medications (Omeprazole, Norco, Ibuprofen and Tizanidine) and a new prescription for Amitriptyline. On 8-25-15, Utilization Review noncertified a request for Omeprazole delayed release 20mg #30, Amitriptyline 25mg #60, Tizanidine 4mg #30 and Ibuprofen 800mg #60.

IMR ISSUES, DECISIONS AND RATIONALES

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

Omeprazole delayed release 20mg every day quantity 30: 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: Omeprazole 20mg #30 is not medically necessary. CA MTUS does not make a direct statement on proton pump inhibitors (PPI) but in the section on NSAID use page 67. Long term use of PPI or misoprostol or Cox-2 selective agents has been shown to increase the risk of Hip fractures. CA MTUS does state that NSAIDs are not recommended for long term use as well and if there possible GI effects of another line of agent should be used for example acetaminophen. Omeprazole is therefore not medically necessary.

Amitriptyline 25mg quantity 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): Amitriptyline.

Decision rationale: Amitriptyline 25 mg quantity 60 is not medically necessary. Ca MTUS page 13-14 states that antidepressants for chronic pain as recommended as first-line option for neuropathic pain and as a possibility for non-neuropathic pain. Tricyclics are generally considered first line agent unless they are ineffective, poorly tolerated, or contraindicated. Analgesia generally occurs within a few days to a week, whereas antidepressant effects take longer to occur. Assessment of treatment efficacy should include not only pain outcomes but also in evaluation of function, changes in the use of other analgesic medication, sleep quality and duration, and psychological assessment. Side effects include excessive sedation (Additional side effects are listed below for each specific drug.) It is recommended that these outcome measurements should be initiated at one week of treatment with a recommended trial of at least

4 weeks. The optimal duration of treatment is not known because most double-blind trials have been of short duration (6-12 weeks). It has been suggested that if pain is in remission for 3-6 months, a gradual tapering of anti-depressants may be undertaken. (Perrot, 2006) (Schnitzer, 2004) (Lin-JAMA, 2003) (Salerno, 2002) (Moulin, 2001) (Fishbain, 2000) (Taylor, 2004) (Gijnsman, 2004) (Jick-JAMA, 2004) (Barbui, 2004) (Asnis, 2004) (Stein, 2003) (Pollack, 2003) (Ticknor, 2004) (Staiger, 2003) Long-term effectiveness of anti-depressants has not been established. (Wong, 2007) The effect of this class of medication in combination with other classes of drugs has not been well researched. The medical records did not document treatment efficacy including pain outcome, function, changes in medication, sleep quality and duration or even provide a true psychological assessment. Given the lack of positive response to the medication as the patient continued to display psychogenic pain as well as permanent disability, Elavil is not medically necessary.

Tizanidine 4mg quantity 30: 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): Muscle relaxants (for pain).

Decision rationale: Tizanidine 4 mg quantity 30 is not medically necessary. Tizanidine (Zanaflex, generic available) is a centrally acting alpha2-adrenergic agonist that is FDA approved for management of spasticity; unlabeled use for low back pain. (Malanga, 2008) Eight studies have demonstrated efficacy for low back pain. (Chou, 2007) One study (conducted only in females) demonstrated a significant decrease in pain associated with chronic myofascial pain syndrome and the authors recommended its use as a first line option to treat myofascial pain. (Malanga, 2002) May also provide benefit as an adjunct treatment for fibromyalgia. (ICSI, 2007) The recommended dosing is 4mg with a max dose of 36 mg per day. The medical records indicate that the zanaflex was prescribed for back pain. MTUS recommends short-term use for myofascial pain or fibromyalgia; therefore, the claim is not medically necessary.

Ibuprofen 800mg one every 12 hours quantity 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: Ibuprofen 800 mg every 12 hours quantity 60 is not medically necessary. Per MTUS guidelines page 67, NSAIDS are recommended for osteoarthritis at the lowest dose for the shortest period in patients with moderate to severe pain so to prevent or lower the risk of complications associate with cardiovascular disease and gastrointestinal distress. The medical records do no document the length of time he has been on oral anti-inflammatories. Additionally, a diagnosis of osteoarthritis has not been documented in the medical records. The medication is therefore not medically necessary.