MAXIMUS Federal Services

Case Number:	CM15-0033048		
Date Assigned:	02/26/2015	Date of Injury:	08/29/2011
Decision Date:	04/07/2015	UR Denial Date:	01/23/2015
Priority:	Standard	Application Received:	02/23/2015

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 Jersey
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 51 year old male, who sustained an industrial injury on August 29, 2011. The diagnoses have included cervical myoligamentous injury, right upper extremity radiculopathy, right carpal tunnel syndrome, ulnar nerve entrapment on the right elbow and wrist and medication-induced gastritis. Treatment to date has included right shoulder arthroscopy, right knee arthroscopy, cervical epidural steroid injection, trigger point injections, medication and diagnostic studies. Currently, the injured worker complains of ongoing debilitation pain in his neck associated with cervicogenic headaches and radicular symptoms into the right upper extremity. An epidural steroid injection in 8/2013 provided 60% pain relief for 3 months. The injured worker uses 1-2 tablets of Norco 10/325 mg per day in addition to his Anaprox and reports that without the medication he has much more pain and is not able to function well. The evaluating physician noted that the treatment plan included a trial of Ultracet as an alternative to Norco. On January 23, 2015 Utilization Review non-certified a request for Prilosec 20 mg #60, noting that there is no documentation of an altered dose of the NSAID or a need for dietary change resulting from gastrointestinal symptoms associated with NSAID or other medications being prescribed. Utilization Review modified a request for Ultracet 37.5/325 mg #60 and Anaprox DS 550 mg #60. The California Medical Treatment Utilization Schedule was cited. On February 23, 2015, the injured worker submitted an application for IMR for review of Anaprox DS 550 mg #60, Prilosec 20 mg #60 and Ultracet 37.5/325 mg #60.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retro Anaprox DS 550mg BID PRN #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 73.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-73.

Decision rationale: The MTUS Guidelines state that NSAIDs (non-steroidal anti-inflammatory drugs) may be recommended for osteoarthritis as long as the lowest dose and shortest period is used. The MTUS also recommends NSAIDs for short-term symptomatic use in the setting of back pain if the patient is experiencing an acute exacerbation of chronic back pain if acetaminophen is not appropriate. NSAIDS are not recommended for neuropathic pain, long-term chronic pain, and relatively contraindicated in those patients with cardiovascular disease, hypertension, kidney disease, at risk for gastrointestinal bleeding. In the case of this worker, there was no specific evidence of functional gains directly related to the Anaprox use. Regardless, there was no convincing explanation found in the documentation which would justify using an NSAID chronically, considering its long-term side effects, based on the diagnoses listed. Therefore, the Anaprox DS 550 mg bid prn #60 will be considered medically unnecessary.

Retro Prilosec 20mg BID PRN #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms and Cardiovascular Risk Page(s): 68-69.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68-69.

Decision rationale: The MTUS Guidelines state that to warrant using a proton pump inhibitor (PPI) in conjunction with an NSAID, the patient would need to display intermediate or high risk for developing a gastrointestinal event such as those older than 65 years old, those with a history of peptic ulcer, GI bleeding, or perforation, or those taking concurrently aspirin, corticosteroids, and/or an anticoagulant, or those taking a high dose or multiple NSAIDs. In the case of this worker, there was insufficient evidence presented in the documentation which would have designated this worker as being at an elevated risk for gastrointestinal events to warrant chronic daily use of a PPI. Therefore the Prilosec will be considered medically unnecessary.

Retro Ultracet 37.5/325mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids. Decision based on Non-MTUS Citation Official Disability Guidelines, Opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78-96.

Decision rationale: The MTUS Chronic Pain Guidelines state that for a therapeutic trial of opioids, there needs to be no other reasonable alternatives to treatments that haven't already been tried, there should be a likelihood that the patient would improve with its use, and there should be no likelihood of abuse or adverse outcome. Before initiating therapy with opioids, the MTUS Chronic Pain Guidelines state that there should be an attempt to determine if the pain is nociceptive or neuropathic (opioids not first-line therapy for neuropathic pain), the patient should have tried and failed non-opioid analgesics, goals with use should be set, baseline pain and functional assessments should be made (social, psychological, daily, and work activities), the patient should have at least one physical and psychosocial assessment by the treating doctor, and a discussion should be had between the treating physician and the patient about the risks and benefits of using opioids. Initiating with a short-acting opioid one at a time is recommended for intermittent pain, and continuous pain is recommended to be treated by an extended release opioid. Only one drug should be changed at a time, and prophylactic treatment of constipation should be initiated. The MTUS Chronic Pain Medical Treatment Guidelines also state that opioids may be considered for moderate to severe chronic pain as a secondary treatment, but require that for continued opioid use, there is to be ongoing review and documentation of pain relief, functional status, appropriate medication use with implementation of a signed opioid contract, drug screening (when appropriate), review of non-opioid means of pain control, using the lowest possible dose, making sure prescriptions are from a single practitioner and pharmacy, and side effects, as well as consultation with pain specialist if after 3 months unsuccessful with opioid use, all in order to improve function as criteria necessary to support the medical necessity of opioids. Long-term use and continuation of opioids requires this comprehensive review with documentation to justify continuation. In the case of this worker, there was insufficient evidence to support the transition to Ultracet from Norco, as was recommended be done by his provider with an unclear reason, but may be related to a suspected shortage of Norco. There was no documented evidence of measurable functional gains directly related to his opioid use to convince the reviewer that another opioid would be warranted. Also, the full review regarding continued opioid therapy as listed above was not fully completed, which would be required for initiation of a new opioid medication. Therefore, the Ultracet will be considered medically unnecessary at this time.