

Case Number:	CM15-0045810		
Date Assigned:	03/18/2015	Date of Injury:	08/11/2010
Decision Date:	04/23/2015	UR Denial Date:	02/11/2015
Priority:	Standard	Application Received:	03/11/2015

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: Texas, Florida, California
 Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

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 49-year-old male, who sustained an industrial injury on August 11, 2010. The injured worker had reported a neck and back injury. The diagnoses have included lumbar degenerative disc disease, discogenic low back pain, right lumbar four-lumbar five radiculitis, cervical discogenic pain, cervical and lumbar myofascial pain and chronic pain syndrome. Treatment to date has included medications, radiological studies, lumbar and cervical epidural steroid injections and electro-diagnostic studies. Most current documentation dated November 17, 2014 notes that the injured worker complained of neck pain, which radiated to the left scapula and low back pain, which radiated to the left lateral thigh. The injured workers current medication regime was noted to be beneficial with no side effects. Physical examination of the cervical spine revealed tenderness of the paraspinal muscles, more on the left. Sensation was decreased in the second and third finger of the left hand. Examination, of the lumbar spine revealed tenderness of the lower paraspinal muscles and a straight leg raise test was negative. The treating physician's recommended plan of care included retrospective Norco 10/325 mg #60 (DOS 2/08/15), retrospective Omeprazole 20 MG #60 (DOS 2/8/15), retrospective Trazodone 50 mg #60 (DOS 2/08/15) and retrospective Naproxen 650 mg #60 (DOS 2/08/15).

IMR ISSUES, DECISIONS AND RATIONALES

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

Retro Norco 10/325 MG 1 By Mouth BID/QID As Needed #60 (DOS 2/08/15): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 Page(s): 88 of 127.

Decision rationale: In regards to the long term use of opiates, the MTUS poses several analytical questions such as has the diagnosis changed, what other medications is the patient taking, are they effective, producing side effects, what treatments have been attempted since the use of opioids, and what is the documentation of pain and functional improvement and compare to baseline. These are important issues, and they have not been addressed in this case. There especially is no documentation of functional improvement with the regimen. The request for long-term opiate usage is not certified per MTUS guideline review. The request IS NOT medically necessary.

Retro Omeprazole 20 MG By Mouth Every 12-24 Hours As Needed #60 (DOS 2/8/15): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 Page(s): 68 of 127.

Decision rationale: The MTUS speaks to the use of Proton Pump Inhibitors like in this case in the context of Non Steroid Anti-inflammatory Prescription. It notes that clinicians should weigh the indications for NSAIDs against gastrointestinal risk factors such as: (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). Sufficient gastrointestinal risks are not noted in these records. The request is appropriately non-certified based on MTUS guideline review. The request IS NOT medically necessary.

Retro Trazodone 50 MG 1-2 By Mouth HS #60 (DOS 2/08/15): Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain chapter, under Antidepressants.

Decision rationale: The current California web-based MTUS collection was reviewed in addressing this request. The guidelines are silent in regards to this request. Therefore, in accordance with state regulation, other evidence-based or mainstream peer-reviewed guidelines

will be examined. Regarding antidepressants to treat a major depressive disorder, the ODG notes: Recommended for initial treatment of presentations of Major Depressive Disorder (MDD) that are moderate, severe, or psychotic, unless electroconvulsive therapy is part of the treatment plan. Not recommended for mild symptoms. In this case, it is not clear what objective benefit has been achieved out of the antidepressant usage, how the activities of daily living have improved, and what other benefits have been. It is not clear if this claimant has a major depressive disorder as defined in DSM-IV. If used for pain, it is not clear what objective, functional benefit has been achieved. If used for insomnia, that is off-label usage which the medicine was not validated for. The request is appropriately non-certified. The request IS NOT medically necessary.

Retro Naproxen 650 MG By Mouth Every 12 Hours As Needed #60 (DOS 2/08/15): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines : Pain interventions and treatments 8 C.C.R. 9792.20 - 9792.26 Page(s): 67 of 127.

Decision rationale: The MTUS recommends NSAID medication for osteoarthritis and pain at the lowest dose, and the shortest period possible. The guides cite that there is no reason to recommend one drug in this class over another based on efficacy. Further, the MTUS cites there is no evidence of long-term effectiveness for pain or function. This claimant though has been on some form of a prescription non-steroidal anti-inflammatory medicine for some time, with no documented objective benefit or functional improvement. The MTUS guideline of the shortest possible period of use is clearly not met. Without evidence of objective, functional benefit, such as improved work ability, improved activities of daily living, or other medicine reduction, the MTUS does not support the use of this medicine. It is appropriately non-certified. The request IS NOT medically necessary.