

Case Number:	CM15-0058207		
Date Assigned:	04/02/2015	Date of Injury:	09/27/2002
Decision Date:	05/21/2015	UR Denial Date:	03/02/2015
Priority:	Standard	Application Received:	03/26/2015

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, Washington

Certification(s)/Specialty: Physical Medicine & Rehabilitation, 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:

The injured worker is a 34 year old male, who sustained an industrial injury on 9/27/2002. The injured worker reported a fall over twelve feet onto his back with loss of consciousness. Diagnoses include cervical disc injury, lumbar strain with disc bulge and facet joint pain, right medial epicondylitis, knee pain, depression and anxiety, headaches and blurred vision. Treatments to date include medication therapy, physical therapy, epidural injections, biofeedback, psychotherapy and cranial electrostimulation. The injured worker presented on 02/11/2015 for a follow up evaluation with complaints of persistent low back pain with lower extremity symptoms. The injured worker reported 6/10 pain with bilateral lower extremity numbness. Upon examination, there was tenderness in the paraspinal musculature of the thoracic and lumbar region, a negative straight leg raise bilaterally, increased pain on extension versus flexion, 2+ bilateral deep tendon reflexes, and no evidence of muscle spasm or pathological reflex. Treatment recommendations included continuation of the current medication regimen. A Request for Authorization form was submitted on 02/11/2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

Motrin 800mg #90 with 3 refills: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67-72.

Decision rationale: California MTUS Guidelines state NSAIDs are recommended for osteoarthritis at the lowest dose for the shortest period in patients with moderate to severe pain. For acute exacerbations of chronic pain, NSAIDs are recommended as a second line option after acetaminophen. In this case, the injured worker has continuously utilized the above medication for an unknown duration. There is no documentation of objective functional improvement. The guidelines do not support long term use of NSAIDs. There is also no frequency listed in the request. As such, the request is not medically necessary.

Norco 10/325mg #45: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

Decision rationale: The California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of nonopioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. The injured worker has continuously utilized the above medication since at least 06/2014. There is no documentation of objective functional improvement. There is also no frequency listed in the request. As such, the request is not medically necessary.

Prilosec 20mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68-69.

Decision rationale: California MTUS Guidelines state, proton pump inhibitors are recommended for patients at intermediate or high risk for gastrointestinal events. Patients with no risk factor and no cardiovascular disease do not require the use of a proton pump inhibitor, even in addition to a nonselective NSAID. In this case, there was no documentation of cardiovascular disease or increased risk factors for gastrointestinal events. The medical necessity for the requested medication has not been established. Additionally, there is no frequency listed in the request. As such, the request is not medically appropriate.

Ambien 10mg #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic).

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

Decision rationale: The Official Disability Guidelines recommend insomnia treatment based on etiology. Ambien is indicated for the short term treatment of insomnia with difficulty of sleep onset for 7 to 10 days. The injured worker does not maintain a diagnosis of insomnia disorder. There is no documentation of a failure to respond to nonpharmacologic treatment prior to the request for a prescription product. There is also no frequency listed in the request. As such, the request is not medically necessary.