MAXIMUS Federal Services

| Case Number: | CM15-0070475 | | |
|---|---|---|---|
| Date Assigned: | 04/17/2015 | Date of Injury: | 11/23/2007 |
| Decision Date: | 09/15/2015 | UR Denial Date: | 03/26/2015 |
| Priority: | Standard | Application Received: | 04/13/2015 |

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

## 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 60 year old male with an industrial injury dated November 23, 2007. The injured worker diagnoses include status post anterior cervical discectomy and fusion (ACDF) at C5-T1, cervical disc disease, cervical radiculopathy, bilateral shoulder impingement, lumbar disc disease, lumbar radiculopathy, and chronic pain. He has been treated with prescribed medications and periodic follow up visits. According to the progress note dated 1/29/2015, the injured worker presented for a follow up of his bilateral shoulder, cervical spine and lumbar spine. The treating physician reported that the injured worker remains with complaints of significant pain and limited range of motion. The pain is exacerbated by overhead activities and the injured worker complains of tightness in shoulders. In a progress note dated 2/6/2015, physical exam revealed wide base gait, decrease cervical range of motion, decrease sensation in the C7-C8 dermatomes bilaterally, diffuse tenderness to palpitation over the lumbar paraspinous with guarding and spasms, moderate facet tenderness to palpitation along the L4-S1 levels, and decreased sensation in the L4-L5 dermatomes bilaterally. The treating physician requested Prilosec, Benicar, Xanax, Ambien, Fiorinal, Percocet and Bystolic, prescribed on 3/12/2015.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Prilosec 20mg, #90, prescribed 03/12/15:** 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 PPI section Page(s): 68-69.

**Decision rationale:** According to the MTUS Chronic Pain Guidelines, Proton Pump Inhibitors are used to treat symptoms of gastritis, peptic ulceration, acid reflux, and/or dyspepsia related to non-steroidal anti-inflammatories (NSAIDs). Within the submitted documentation, there is no mention of the injured worker having GERD, dyspepsia due to NSAIDs, or any of other above mentioned issues that would warrant Prilosec. Furthermore, there is no frequency listed in this particular request. As such, this request is not medically necessary.

**Benicar 40mg, #30, prescribed 03/12/15:** 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), Diabetes; drugs.com.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Diabetes and Hypertension Treatment Section.

**Decision rationale:** According to the ODG, Benicar is used to treat hypertension. Within the submitted documentation, there is lack of evidence to support a diagnosis of hypertension, and there is lack of mention of Benicar working well to treat the injured worker for hypertension. Without supporting documentation, this request cannot be considered medically necessary or appropriate.

**Xanax 1mg, #90, prescribed 03/12/15:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines. Decision based on Non-MTUS Citation ODG: Pain Chapter.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Section 2 Page(s): 24.

**Decision rationale:** California MTUS guidelines state that benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there are risks of dependency. Guidelines generally limit use to 4 weeks. Chronic benzodiazepines are the treatment of choice in very few conditions. Within the submitted documentation, there is no mention of previous functional or objective benefit from past use of Xanax. Long-term use is not recommended. There is no frequency listed with the request. As such, this request is not medically necessary.

**Ambien 10mg, #30, prescribed 03/12/15:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG: Pain Chapter; NEJM Journal Watch.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Ambien, 11th Edition, 2013.

**Decision rationale:** Ambien is a prescription short-acting non-benzodiazepine hypnotic, which is approved for the short-term (usually two to six weeks) treatment of insomnia. They are not recommended for long-term use. They can be habit-forming and impair function and memory more than opioid pain relievers. Within the submitted documentation, there is no mention of chronic insomnia, nor is there mention of objective improvement with Ambien, improved daytime functioning, and/or improved sleep pattern. This request is not medically necessary.

**Fiorinal 50/325/40mg, #90, prescribed 03/12/15:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Fioricet. Decision based on Non-MTUS Citation Medline Plus.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Barbiturate Analgesics Page(s): 23.

**Decision rationale:** Fiorinal (Butalbital/aspirin/caffeine) is classified under barbiturate-containing analgesics (BCA). CA MTUS Chronic Pain Medical Treatment Guidelines state that these compounds are not recommended for chronic pain, and have high potential for drug dependence with no evidence to show clinically important enhancement of analgesia. There is risk of medication overuse, as well as rebound headache. There is no mention of headache, no mention of objective or functional improvement with this medication, and long term use is not recommended. There is no frequency listed with the request, and as such, this request is not medically necessary.

**Percocet 10/325mg, #120, prescribed 03/12/15:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for chronic pain. Decision based on Non-MTUS Citation ODG: Pain Chapter.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Ongoing pain management section.

**Decision rationale:** According to the California MTUS, ongoing pain medications can be considered if the 4 As have been established. The 4 As include analgesia, activities of daily living, aberrant drug taking behavior, and adverse side effects. There is no mention of Percocet contributing to improvement in activities of daily living, nor is there mention of monitoring for

adverse side effects or aberrant behavior. Pain scales before and after use of Percocet were not addressed. No frequency was listed. As a result, this request is not medically necessary.

**Bystolic 20mg, #30, prescribed 03/12/15:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG: Diabetes; drugs.com.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation FDA, 2014 Physician Desk Reference.

**Decision rationale:** According to the FDA, Bystolic is used to treat hypertension. The MTUS and ODG are silent on this medication. There is no mention of hypertension within the submitted documentation, that has been adequately treated with this particular agent. Without documentation supporting a diagnosis of hypertension, this request is not medically necessary.