

Case Number:	CM14-0145635		
Date Assigned:	09/12/2014	Date of Injury:	05/02/2000
Decision Date:	10/14/2014	UR Denial Date:	08/29/2014
Priority:	Standard	Application Received:	09/08/2014

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. The expert reviewer is Board Certified in Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in Florida. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 66-year-old female who reported an injury on 05/02/2000. The mechanism of injury was not submitted for review. The injured worker has diagnoses of degeneration of cervical intervertebral discs, degeneration of the intervertebral disc site unspecified, and otherwise unspecified disc disorder of the cervical and lumbar region. Past medical treatment consists of physical therapy, chiropractic therapy, and medication therapy. Medications included amitriptyline, esomeprazole, Naprosyn, and Norco. On 02/26/2014, a urinalysis was done showing that the injured worker was in compliance with medication. On 08/21/2014, the injured worker complained of back and neck pain. It was noted in physical examination that the injured worker had a pain rate of 8/10 with medication and 10/10 without. It was noted in the exam that the injured worker had a neck flexion of 30 degrees, extension of 30 degrees, and lateral rotation to the right and left 50 degrees. It was noted that there was a positive Spurling's sign on the left, slight atrophy of both upper extremities. Deep tendon reflexes were stable at 1+ on the left and 2+ on the right. Lumbar spine revealed range of motion was 70/5, very tender to palpation with muscle spasm. There was a positive straight leg raise to the right. Deep tendon reflexes were 0/4 to 1/4, but equal bilaterally. The treatment plan is for the injured worker to continue the use of medication. The rationale was not submitted for review. The Request for Authorization form was submitted on 04/25/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325mg #180 with 2 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Norco, Ongoing Management Page(s): 75, 78.

Decision rationale: The request for Norco 10/325mg #180 with 2 refills is not medically necessary. The California MTUS Guidelines recommend short acting opioids, such as Norco, for controlling chronic pain. For ongoing management, there should be documentation of the 4 A's for ongoing monitoring including analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors. Guidelines also state that there should be an assessment of what pain levels were before, during, and after administration of the medication. The submitted documentation did not indicate if the medication was helping with any functional deficits the injured worker might have had. Additionally, the efficacy of the medication was not submitted for review. A urinalysis submitted on 02/26/2014 showed that the injured worker was in compliance with her prescription medications; however, there was no assessment showing what pain level were before, during, and after administration of the medication. Additionally, the submitted documentation lacked any evidence of the injured worker having any adverse side effects. Given the above, the injured worker is not within the MTUS recommended guidelines. As such, the request is not medically necessary.

Naprosyn 500mg #60 with 5 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Naproxen (Naprosyn).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Naprosyn Page(s): 22, 73.

Decision rationale: The request for Naprosyn 500mg #60 with 5 refills is not medically necessary. The California MTUS Guidelines indicate that Naprosyn is a nonsteroidal anti-inflammatory drug for the relief of the signs and symptoms of osteoarthritis and the guidelines recommend the lowest effective dose be used for all NSAIDs for the shortest duration of time consistent with the individual patient treatment goals. The comprehensive of clinical trials on the efficacy and safety of drugs for treatment of low back pain concludes that available evidence supports the efficacy of nonselective, nonsteroidal anti-inflammatory drugs in chronic low back pain. The submitted documentation did not indicate the efficacy of the medication. There was no evidence reporting what the injured worker's measurable pain levels were before, during, and after medication. Furthermore, there was no indication in the submitted reports whether the medication was helping the injured worker with any functional deficits. Additionally, guidelines recommend anti-inflammatories for first line treatment, but do not recommend them for long term use. The submitted reports indicate that the injured worker had been taking Naprosyn since at least 02/21/2013, exceeding the recommended guidelines for short term use. Given the above, the injured worker is not within the MTUS recommended guidelines. As such, the request for Naprosyn 500mg #60 with 5 refills is not medically necessary.

Esomeprazole 40mg #30 with 5 refills: 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 GI symptoms & cardiovascular risk Page(s): 68.

Decision rationale: The request for Esomeprazole 40mg #30 with 5 refills is not medically necessary. The MTUS Chronic Pain Guidelines state that proton pump inhibitors may be recommended to treat dyspepsia secondary to NSAID therapy. The addition of a proton pump inhibitor is also supported for patients taking NSAID medication who have cardiovascular disease or significant risk factors for gastrointestinal events. It was noted in the documented report that the injured worker had been taking Naprosyn since at least 02/2013; however, there was no documentation indicating that the injured worker had complaints of dyspepsia with the use of the medication, cardiovascular disease, or significant risk factors for gastrointestinal events. In the absence of this documentation, the request is not supported by evidence based guidelines. Additionally, the request as submitted did not indicate a frequency of the medication. As such, the request for Esomeprazole 40mg #30 with 5 refills is not medically necessary.

Amitriptyline 10mg #90 with 2 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Amitriptyline Page(s): 13.

Decision rationale: The request for Amitriptyline 10mg #90 with 2 refills is not medically necessary. The MTUS recommend the use of amitriptyline. Amitriptyline is a tricyclic antidepressant. Tricyclics are generally considered a first line agent unless they are ineffective, poorly tolerated, or contraindicated. MTUS guidelines also state that they are recommended as a first line option for neuropathic pain, and as a possibility for non-neuropathic pain. Assessment of treatment efficacy should include not only pain outcomes, but also an evaluation of function, changes in the use of other analgesic medication, sleep quality and duration, and psychological assessment. It is recommended that these outcome measurements should be initiated at 1 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 a short duration (6 to 12 weeks). Long term effectiveness of antidepressants has not been established. The effect of this class of medication in combination with other classes of drugs has not been well researched. The submitted documentation did not include the efficacy of the medication. Additionally, there was no evaluation of function, changes in use of any other use of analgesic medications, sleep quality and duration. There was also no psychological assessments submitted for review. There was also a lack of any indication of side effects the injured worker might be having with the medication. It was also noted that the injured worker had been on the medication since at least

02/2013. Given the above, the injured worker is not within the MTUS recommended guidelines. As such, the request is not medically necessary.