

Case Number:	CM14-0161251		
Date Assigned:	10/06/2014	Date of Injury:	08/01/1993
Decision Date:	11/03/2014	UR Denial Date:	09/16/2014
Priority:	Standard	Application Received:	10/01/2014

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 Physical Medicine and Rehabilitation and is licensed to practice in Illinois. 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 53 year old male with a date of injury of 08/01/1993. The mechanism of injury is not included in the medical record. His relevant diagnoses are cervical degenerative disc disease with facet arthropathy and bilateral upper extremity radiculopathy; thoracic spine sprain/strain syndrome; lumbar degenerative disc disease; bilateral peroneal neuropathy; bilateral knee internal derangement; left ankle traumatic arthritis; medication induced gastritis and bilateral ulnar nerve entrapment. His past treatments include cervical epidural steroid injection and lumbar epidural steroid injection. On 08/29/2014, the injured worker reported increased pain in his neck with radiating symptoms to his bilateral upper extremities, rated 6/10. His medications were noted to include Norco 10/325mg, Ultram ER 150mg, Anaprox 550mg, Zanaflex 4mg, Prilosec 20mg, Xanax 1mg, Trazodone 150mg, Lexapro 10mg, Dendracin topical analgesic cream. The treatment plan includes epidural steroid injections, medication refills, and various follow-up visits with his other providers. A request was received for Retro Anaprox DS 550mg#60, Retro Ultram ER 150mg everyday #30, Retro Prilosec 20mg #60, and Retro Norco 10/325mg #240. No rationale was provided for these requests. The Request for Authorization form was also not provided in the medical records.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retro Anaprox DS 550mg#60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 67-68.

Decision rationale: The request for Retro Anaprox DS 550mg#60 is not medically necessary. The California MTUS Guidelines indicate that NSAID's are recommended as an option for short-term symptomatic relief and state that Cochrane review of the literature on drug relief for low back pain (LBP) suggested that NSAIDs were no more effective than other drugs such as acetaminophen, narcotic analgesics, and muscle relaxants. The review also found that NSAIDs had more adverse effects than placebo and acetaminophen but fewer effects than muscle relaxants and narcotic analgesics. The injured worker has been taking this medication since at least 01/16/2014. However, there was insufficient documentation showing efficacy with evidence of decreased objective pain scores with and without medication, and increased function. There was also no documentation regarding adverse effects or labs monitoring of liver and kidney functions, as recommended by the guidelines. There is not a frequency indicated in the request for this medication. Additionally, the request, as submitted, did not specify a frequency of use. Based on the above, the request is not medically necessary.

Retro Ultram ER 150mg Everyday #30: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for Use, On-going.

Decision rationale: The request for Retro Ultram ER 150mg Everyday #30 is not medically necessary. According to the California MTUS Guidelines, the ongoing monitoring of opioid use should include detailed documentation of pain relief, functional status, appropriate medication use with evidence of consistent results on urine drug screening, and adverse side effects. The medical record indicates this medication has been prescribed since 01/16/2014. There are no results showing the monitoring of pain levels before and after the opioid was taken, nor documentation regarding functional status or adverse side effects. There are also no results of recent urine drug testing. Subsequently, the request is not medically necessary.

Retro Prilosec 20mg #60: Upheld

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

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

Decision rationale: The request for Retro Prilosec 20mg #60 is not medically necessary. The California MTUS Guidelines may recommend proton pump inhibitors for patients taking NSAIDs with significant risk of GI symptoms or to treat dyspepsia secondary to NSAID therapy. The injured worker has been taking this medication since at least 01/16/2014 and was shown to be taking an NSAID medication. He also has a diagnosis of medication induced gastritis. However, the medication which causes this adverse effect and details regarding this diagnosis were not provided. Additionally, there was no documentation showing the use of Prilosec provided benefit. Moreover, the request, as submitted, did not specify a frequency of use. As such, the request is not medically necessary.

Retro Norco 10/325mg #240: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for Use, On-going Management Page(s): 78.

Decision rationale: The request for Retro Norco 10/325mg #240 is not medically necessary. According to the California MTUS Guidelines, the ongoing monitoring of opioid use should include detailed documentation of pain relief, functional status, appropriate medication use with evidence of consistent results on urine drug screening, and adverse side effects. The injured worker has been taking this medication since at least 01/16/2014. There are no results showing the monitoring of pain levels before and after the opioid was taken, nor documentation regarding functional status or adverse side effects. There are also no results of recent urine drug testing. Additionally, the request, as submitted, did not specify a frequency of use. Subsequently, the request is not medically necessary.