

Case Number:	CM14-0211846		
Date Assigned:	01/14/2015	Date of Injury:	12/24/2001
Decision Date:	03/10/2015	UR Denial Date:	12/03/2014
Priority:	Standard	Application Received:	12/17/2014

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. 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, District of Columbia, Maryland
 Certification(s)/Specialty: Anesthesiology, 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 records presented for review reflect that this 52-year-old individual was injured on December 24, 2001. Initial progress (for you is dated April 9, 2007 and this is a QME assessment. The injured employee is noted to be 5'5", 170 pounds and no acute distress. It was opined that the treatment to date (April, 2007) was reasonably required to address the injury sustained. This included surgical intervention. It was determined that maximum medical improvement had been reached. The next document is dated March 22, 2009 and representd an additional QME assessment. It was determined that additional care was necessary and the permanent and stationary assessment was rescinded. Additional physical therapy for the certification right wrist, a steroid injection for the coccydynia, and epidural steroid injection is suggested. Additional follow-up for the medication management is also endorsed. The progress notes through December 23, 2012 continue the medication protocol. A home exercise program is also endorsed. A third QME evaluation was completed on February 20, 2013. The interplay continues under the care of the spine surgeon and a left carpal tunnel release has been completed. The employee is not work subsequent to 2008. There are complaints of neck pain, low back pain, and changes associate with carpal tunnel syndrome and coccydynia. This assessment noted the spine surgery was a function of the injury, and continued treatment for the neck, left wrist and coccyx is identified. The April 15, 2014 note indicates lower extremity symptomology, bilateral foot issues, and a request for a caudal epidural steroid injection. A fourth QME evaluation was completed on June 25, 2014. The injured employee is described as being temporary totally disabled. It was opined of future medical care would include lumbar epidural steroid injections

and repeat neurodiagnostic studies. A narrative from the training provided it is September 29, 2014 attended to explain the need for the medications Norco, Prilosec, Ultram, Fexmid and Nalfon. The progress note dated November 3, 2014 indicate that there are headaches which all are "aggravated by the back pain."

IMR ISSUES, DECISIONS AND RATIONALES

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

Imitrex 50mg # 18: 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), Head (Acute & Chronic)

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

Decision rationale: This medication is a triptan, and is recommended for migraine sufferers and the headaches appear to be a function of a lumbar injury. Therefore, based on the complete lack of clinical information presented, there is no objective basis on which to support this medication. It is also unclear why two triptans are being prescribed.

Prilosec 20mg #90: 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 NSAIDs, GI Symptoms & Cardiovascular Risk Page(s): 68.

Decision rationale: In the treatment of dyspepsia secondary to NSAID therapy, the MTUS recommends stopping the NSAID, switching to a different NSAID, or considering the use of an H2-receptor antagonist or a PPI. The MTUS Chronic Pain Medical Treatment Guidelines recommend the use of proton pump inhibitors in conjunction with NSAIDs in situations in which the patient is at risk for gastrointestinal events including: (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). CPMTG guidelines further specify: "Recommendations: Patients with no risk factor and no cardiovascular disease: Non-selective NSAIDs OK (e.g, ibuprofen, naproxen, etc.) Patients at intermediate risk for gastrointestinal events and no cardiovascular disease: (1) A non-selective NSAID with either a PPI (Proton Pump Inhibitor, for example, 20 mg omeprazole daily) or misoprostol (200 g four times daily) or (2) a Cox-2 selective agent. Long-term PPI use (> 1 year) has been shown to increase the risk of hip fracture (adjusted odds ratio 1.44). Patients at high risk for gastrointestinal events with no cardiovascular disease: A Cox-2 selective agent plus a PPI if absolutely necessary. Patients at high risk of gastrointestinal events with cardiovascular disease: If GI risk is high the suggestion is for a low-dose Cox-2 plus low dose Aspirin (for cardioprotection) and a

PPI. If cardiovascular risk is greater than GI risk the suggestion is naproxyn plus low-dose aspirin plus a PPI. (Laine, 2006) (Scholmerich, 2006) (Nielsen, 2006) (Chan, 2004) (Gold, 2007) (Laine, 2007)"Per ODG TWC, "many prescribers believe that this class of drugs is innocuous, but much information is available to demonstrate otherwise. A trial of omeprazole or lansoprazole is recommended before Nexium therapy. The other PPIs, Protonix, Dexilant, and Aciphex, should also be second-line."As there is no documentation of peptic ulcer, GI bleeding or perforation, or cardiovascular disease in the records available for my review, the injured worker's risk for gastrointestinal events is low, as such, medical necessity cannot be affirmed.

Maxalt 5mg #18: 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), Head (Acute & Chronic)

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

Decision rationale: This medication is a triptan, and is recommended for migraine sufferers and the headaches appear to be a function of a lumbar injury. Therefore, based on the complete lack of clinical information presented, there is no objective basis on which to support this medication. It is also unclear why two triptans are being prescribed.

Caudal Epidural Steroid Injection: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injection Page(s): 46.

Decision rationale: Per the MTUS CPMTG epidural steroid injections are used to reduce pain and inflammation, restoring range of motion and thereby facilitating progress in more active treatment programs and avoiding surgery, but this treatment alone offers no significant long-term benefit. The criteria for the use of epidural steroid injections are as follows: 1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing.2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants).3) Injections should be performed using fluoroscopy (live x-ray) for guidance.4) If used for diagnostic purposes, a maximum of two injections should be performed. A second block is not recommended if there is inadequate response to the first block. Diagnostic blocks should be at an interval of at least one to two weeks between injections.5) No more than two nerve root levels should be injected using transforaminal blocks.6) No more than one interlaminar level should be injected at one session.7) In the therapeutic phase, repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks, with a general recommendation of no more than 4 blocks

per region per year. (Manchikanti, 2003) (CMS, 2004) (Boswell, 2007)8) Current research does not support a "series-of-three" injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections. The medical records indicate chronic low back pain however there is no physical examination evidence of a radiculopathy. Therefore, the standards noted in the MTUS are not met and this is not clinically indicated.