

| | | | |
|-----------------------|--------------|------------------------------|------------|
| Case Number: | CM15-0061585 | | |
| Date Assigned: | 04/07/2015 | Date of Injury: | 07/20/2010 |
| Decision Date: | 06/01/2015 | UR Denial Date: | 03/25/2015 |
| Priority: | Standard | Application Received: | 04/01/2015 |

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

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & General Preventive Medicine

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 58 year old female, who sustained an industrial injury on 07/20/2010. The injured worker reported a stool coming from underneath her and she fell onto her back. The injured worker was diagnosed as having cervicalgia, lumbosacral neuritis/radiculitis and left shoulder impingement and hip pain. There is no record of a recent diagnostic study. Treatment to date has included therapy and medication management. In a progress note dated 01/22/2015, the injured worker complains of neck pain that radiated to the bilateral upper extremities with associated headaches and low back pain. Upon examination of the cervical spine, there was paravertebral muscle tenderness with spasm, positive axial loading compression test, positive Spurling's maneuver, limited range of motion, tingling and numbness in the C5-6 and C6-7 distributions, and 4/5 motor weakness. Examination of the left shoulder revealed tenderness over the AC joint, positive Hawkins and impingement sign, painful and limited range of motion, and weakness. Examination of the lumbar spine revealed paravertebral muscle tenderness with spasm, positive seated nerve root test, painful range of motion, guarding, numbness in the L5-S1 distribution, and 4/5 motor weakness. There was tenderness to palpation over the anterolateral aspect of the hip and pain with hip rotation. Treatment recommendations at that time included an MRI of the cervical spine and thoracic spine, bilateral upper extremities and bilateral lower extremities electrodiagnostic studies, MRI of the lumbar spine, and continuation of the current medication regimen. There was no Request for Authorization form submitted for this review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Fenoprofen Calcium Nalfon 400mg, 1 pill 3 times a day, Qty 120: Upheld

Claims Administrator guideline: Decision based on MTUS 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. It is unclear how long the injured worker has utilized the above medication. There is no documentation of objective functional improvement. Guidelines would not support long term use of muscle relaxants. Given the above, the request is not medically necessary.

Omeprazole 20mg, 1 by mouth every 12 hours as needed, Qty 120: 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. As such, the request is not medically appropriate.

Cyclobenzaprine Hydrochloride 7.5mg, 1 by mouth every 8 hour as needed, Qty 120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63-66.

Decision rationale: California MTUS Guidelines state muscle relaxants are recommended as nonsedating second line options for short term treatment of acute exacerbations. Cyclobenzaprine should not be used for longer than 2 to 3 weeks. It is unclear whether the

injured worker has previously utilized the above medication. There is no documentation of objective functional improvement. Guidelines would not support long term use of muscle relaxants. Given the above, the request is not medically necessary.

Eszopiclone tablets 1 mg, 1 at bedtime as needed Qty 30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Pain Chapter, Insomnia Treatment.

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. Lunesta has demonstrated reduced sleep latency and sleep maintenance. The injured worker does not maintain a diagnosis of insomnia disorder. The medical necessity has not been established in this case. There is also no evidence of a failure of nonpharmacologic treatment. Given the above, the request is not medically necessary.