MAXIMUS Federal Services

Case Number:	CM15-0070514		
Date Assigned:	04/20/2015	Date of Injury:	09/27/2003
Decision Date:	06/15/2015	UR Denial Date:	04/08/2015
Priority:	Standard	Application Received:	04/14/2015

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: New York
Certification(s)/Specialty: Anesthesiology

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 43-year-old, male who sustained a work related injury on 9/27/03. The diagnoses have included cervical musculoligamentous strain/sprain, cervical disc herniation, status post cervical spine surgery, lumbar disc protrusion and lumbar disc tear. The treatments have included MRIs, cervical spine surgery, lumbar spine surgery, chiropractic treatments, use of back brace, physical therapy and medications. In the PR-2 dated 3/21/15, the injured worker complains of persistent pain in the neck-cervical spine. He rates this pain an 8/10. He also complains of low back pain-lumbar spine pain. He rates this pain a 7/10. The pain is made better with rest and medications. The pain is made worse with activities. The treatment plan is prescription refills of medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective request for one (1) medication Norco 10/325mg #90 (DOS: 3/16/15 and 4/6/15): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 91-97. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Opioids.

Decision rationale: According to the CA MTUS and ODG, Norco 10/325mg (Hydrocodone/ Acetaminophen) is a short-acting opioid analgesic indicated for moderate to moderately severe pain, and is used to manage both acute and chronic pain. The treatment of chronic pain with any opioid analgesic requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. A pain assessment should include current pain, intensity of pain after taking the opiate, and the duration of pain relief. In this case, there is no documentation of the medication's functional benefit. Medical necessity of the requested item was not been established. Of note, discontinuation of an opioid analgesic should include a taper, to avoid withdrawal symptoms. The retrospective requested medication was not medically necessary.

Retrospective request for One (1) medication Ibuprofen 800mg #60 (DOS: 3/16/15): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-71. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) NSAIDs.

Decision rationale: Motrin (Ibuprofen) is a non-steroidal anti-inflammatory drug (NSAID). Oral NSAIDs are recommended for the treatment of chronic pain and control of inflammation as a second-line therapy after acetaminophen. ODG states that NSAIDs are recommended for acute pain, osteoarthritis and acute exacerbations of chronic pain. There is no evidence of long-term effectiveness for pain or function. There is inconsistent evidence for the use of NSAIDs to treat long-term neuropathic pain. Guidelines recommended that the lowest effective dose be used for the shortest duration of time consistent with treatment goals. In this case, the patient has been on previous long-term NSAIDs without any documentation of significant improvement. Medical necessity of the requested medication, Ibuprofen 800mg, has not been established. The request for this medication is not medically necessary.

Retrospective request for one (1) medication Omeprazole 20mg #60 (DOS: 3/16/15): 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 PPIs Page(s): 68. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) PPIs.

Decision rationale: According to the California MTUS (2009), Omeprazole (Prilosec), is proton pump inhibitor (PPI) that is recommended for patients taking NSAIDs, with documented GI distress symptoms, or at risk for gastrointestinal events. GI risk factors include: age >65, history

of peptic ulcer, GI bleeding, or perforation; concurrent use of aspirin, corticosteroids, and/or anticoagulants, or high dose/multiple NSAIDs. PPIs are highly effective for their approved indications, including preventing gastric ulcers induced by NSAIDs. In this case, there is no documentation indicating that this patient had any GI symptoms or risk factors. In addition, the request for Ibuprofen was not found to be medically necessary, which would mean that the Omeprazole would not appear to be medically necessary for this patient. Medical necessity for Omeprazole was not been established. The requested retrospective medication was not medically necessary.

Retrospective request for one (1) medication Zolpidem 5mg #30 (DOS: 3/16/15): 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), Zolpidem (Ambien).

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

Decision rationale: Ambien (Zolpidem) is a prescription short-acting non-benzodiazepine hypnotic, which is approved for the short-term treatment of insomnia (usually two to six weeks) and is rarely recommended for long-term use. It can be habit-forming, and may impair function and memory more than opioid analgesics, and may increase pain and depression over the long-term. The treatment of insomnia should be based on the etiology and pharmacological agents should only be used after careful evaluation of potential causes of sleep disturbance. In this case, there was no documentation regarding a comprehensive work-up regarding potential sources of the patient's insomnia prior to prescribing a hypnotic, such as Zolpidem. There is no documentation that this patient has a problem with sleep. There was no documentation provided indicating medical necessity for Ambien. The requested retrospective medication was not medically necessary.