MAXIMUS Federal Services

Case Number:	CM15-0093116		
Date Assigned:	05/20/2015	Date of Injury:	09/09/2005
Decision Date:	06/18/2015	UR Denial Date:	04/16/2015
Priority:	Standard	Application Received:	05/15/2015

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: Physical Medicine & Rehabilitation

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 55 year old male/female, who sustained an industrial injury on 9/09/2005. The medical records submitted for this review did not include the details of the initial injury or prior treatments to date. Diagnoses include cervical radicular pain, bilateral shoulder impingement, status post right knee surgery, lumbar fusion, and left shoulder surgery, depression, symptomatic hardware and hernia. Currently, he/she complained of pain in bilateral knees, low back, neck and occipital region. This was associated with headaches. The pain was rated 4/10 with medication and 9/10 without medications. On 11/26/14, the physical examination documented muscle spasms and tenderness along cervical and lumbar spine. There was decreased painful range of motion and decreased sensation noted. The straight leg raise test was positive bilaterally. The right knee revealed crepitation and joint line pain. There was a primary treating physician's medication rational dated 1/29/15, with no new objective or subjective findings documented. This review was for Temaxipam 30 mg #60, Ibuprofen 800mg #180, and Omeprazole 20mg #120 from date of service (DOS) 1/29/15.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective Temazepam 30 mg #60 1-29-15: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), pain chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines, page 24.

Decision rationale: Temazepam (Restoril) is a benzodiazepine hypnotic often prescribed for the treatment of anxiety/ insomnia. Per the MTUS Chronic Pain Treatment Guidelines, chronic benzodiazepines are the treatment of choice in very few conditions with tolerance to hypnotic effects developing rapidly with anxiolytic effects occurring within months; limiting its use to 4 weeks as long-term use may actually increase anxiety. Submitted reports have not demonstrated any clinical findings or specific sleep issues such as number of hours of sleep, difficulty getting to sleep or staying asleep or how use of this sedative/hypnotic has provided any functional improvement from treatment already rendered. The Retrospective Temazepam 30 mg #60 1-29-15 is not medically necessary and appropriate.

Retrospective Ibuprofen 800 mg #180 1-29-15: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 47, 48. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), pain chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs), Page 22.

Decision rationale: Anti-inflammatories are the traditional first line of treatment, to reduce pain so activity and functional restoration can resume, but long-term use may not be warranted. Monitoring of NSAID's functional benefit is advised as per Guidelines, long-term use of NSAIDS beyond a few weeks may actually retard muscle and connective tissue healing and increase the risk of hip fractures. Available reports submitted have not adequately addressed the indication to continue a NSAID for a chronic injury nor have they demonstrated any functional efficacy derived from treatment already rendered. The Retrospective Ibuprofen 800 mg #180 1-29-15 is not medically necessary and appropriate.

Retrospective Omeprazole 20 mg #120 1-29-15: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms, cardiovascular risk Page(s): 68-69. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), pain chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms and Cardiovascular risk, Pages 68-69.

Decision rationale: Prilosec (Omeprazole) medication is for treatment of the problems associated with erosive esophagitis from GERD, or in patients with hypersecretion diseases. Per

MTUS Chronic Pain Treatment Guidelines, the patient does not meet criteria for Omeprazole (Prilosec) namely reserved for patients with history of prior GI bleeding, the elderly (over 65 years), diabetics, and chronic cigarette smokers. Submitted reports have not described or provided any GI diagnosis that meets the criteria to indicate medical treatment. Review of the records show no documentation of any history, symptoms, or GI diagnosis to warrant this medication. The Retrospective Omeprazole 20 mg #120 1-29-15 is not medically necessary and appropriate.