

Case Number:	CM15-0125948		
Date Assigned:	07/10/2015	Date of Injury:	06/08/2011
Decision Date:	10/07/2015	UR Denial Date:	06/10/2015
Priority:	Standard	Application Received:	06/30/2015

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: Pediatrics, Internal 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 36 year old female, who sustained an industrial injury on 6/8/2011. The current diagnoses are multi-level disc herniation of the lumbar spine, lumbar facet arthropathy, right shoulder subacromial bursitis and impingement, right elbow medial epicondylitis, and right carpal tunnel syndrome. According to the progress report dated 5/28/2015, the injured worker complains of persistent right-sided neck and back pain. Her neck pain radiates down her right arm to the level of her hand associated with numbness and tingling in her right hand extending into her fingers. She describes her low back pain as burning in nature with occasional muscle spasms. The pain is rated 8/10 on a subjective pain scale. In addition, she reports persistent anxiety and depression secondary to pain. The physical examination reveals a mildly antalgic gait, decreased range of motion in the cervical, thoracic, and lumbar spine, positive lumbar facet loading bilaterally, right greater than left, and tenderness to palpation over the cervical and lumbar paraspinous regions bilaterally, diminished sensation in the right C6-C8 dermatomes, and decreased strength in the internal and external rotators. The current medications are Diclofenac, Tylenol #3, and Prilosec. There is documentation of ongoing treatment with Tylenol #3 since at least 11/14/2014. Treatment to date has included medication management, lumbar corset, TENS unit, MRI studies, home exercise program, electrodiagnostic testing, 18 chiropractic sessions (temporary relief), and 2-3 acupuncture sessions (no relief). According to the PR-2 from 2/10/2015, she continues working without restrictions. A request for Omeprazole, APAP with Codeine, Lidoderm patches, psychological follow-ups, and psychiatry consultation has been submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Omeprazole 20mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk.

Decision rationale: The CA MTUS Chronic Pain Medical Treatment Guidelines recommend proton pump inhibitors (PPI) when a patient is considered to be at intermediate or high risk for gastrointestinal events or cardiovascular disease. PPIs should be used with precautions. The clinicians should weigh the indications for NSAIDs against gastrointestinal risk factors. Factors determining if a patient is at risk for gastrointestinal events include: age greater than 65 years, history of peptic ulcer, GI (gastrointestinal) bleeding, or perforation, concurrent use of aspirin, corticosteroids, and/or anticoagulant or high dose/multiple NSAID use. Routine use of PPIs is not recommended as long-term use has been shown to increase the risk of hip fractures. In this case, there is no documentation that the injured worker is at risk for gastrointestinal events or cardiovascular complications, and therefore non-selective, non-steroidal anti-inflammatory medications do not need to be accompanied with a PPI. Therefore, based on CA MTUS guidelines and submitted medical records, the request for Omeprazole is not medically necessary.

APAP with Codeine 300/30mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids (Classification), Opioids, California Controlled Substance Utilization Review and Evaluation System (CURES) [DWC], Opioids, criteria for use, Opioids for chronic pain, Opioids for neuropathic pain, Opioids for osteoarthritis, Opioids, cancer pain vs. nonmalignant pain, Opioids, dealing with misuse & addiction, Opioids, differentiation: dependence & addiction, Opioids, dosing, Opioids, indicators for addiction, Opioids, long-term assessment.

Decision rationale: According to the CA MTUS Chronic Pain Medical Treatment Guidelines, Tylenol with Codeine is recommended as an option for mild to moderate pain. Codeine is a schedule C-II controlled substance, but Codeine with Acetaminophen is a C-III controlled substance. Opioid analgesics are not recommended as a first-line oral analgesic. As with any opioid, documentation of ongoing monitoring of the 4 A's, which include detailed pain levels (baseline, average, least, and worst). These are necessary to meet the CA MTUS guidelines. In this case, there is no documentation of functional benefit or improvement as a reduction in

work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result. In addition, the submitted medical records failed to provide documentation regarding baseline pain, functional assessments, and patient goals to support the use of Opioids. Therefore, based on CA MTUS guidelines and submitted medical records, the request for Tylenol #3 is not medically necessary.

Lidoderm patches 5% #1 box: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: According to the CA MTUS Chronic Pain Medical Treatment Guidelines, Lidoderm is a topical analgesic recommended for localized peripheral pain. Topical analgesics are recommended as an option as indicated below. Largely experimental in use with few randomized controlled trials to determine efficacy or safety. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. In this case, there is no documentation that the injured worker has failed a trial of oral antiepileptic and antidepressant medications to support the use of topical analgesics as required by the CA MTUS. Therefore, based on MTUS guidelines and submitted medical records, the request for Lidoderm patch is not medically necessary.

Unknown psychological follow-ups: Upheld

Claims Administrator guideline: Decision based on MTUS Stress-Related Conditions 2004.

MAXIMUS guideline: Decision based on MTUS Stress-Related Conditions 2004, Section(s): General Approach, Models and Definitions, Initial Assessment, Medical, Physical Examination, Diagnostic Testing, Treatment, Work-Relatedness, Follow-up, Failure, References.

Decision rationale: Per the CA MTUS ACOEM Medical Treatment Guidelines, specialty referrals may be necessary when patients have significant psychopathology or serious medical comorbidities. Some mental illnesses are chronic conditions, so establishing a good working relationship with the patient may facilitate a referral or the return-to-work process. It is recommended that serious conditions such as severe depression and schizophrenia be referred to a specialist, while common psychiatric conditions, such as mild depression, be referred to a specialist after symptoms continue for more than six to eight weeks. The practitioner should use his or her best professional judgment in determining the type of specialist. Issues regarding work stress and person-job fit may be handled effectively with talk therapy through a psychologist or other mental health professional. Patients with more serious conditions may need a referral to a psychiatrist for medicine therapy. In this case, the submitted medical records failed to provide documentation that the injured worker suffers from a serious condition such as

severe depression or schizophrenia that would support psychological follow-ups. Therefore, based on CA ACOEM guidelines and submitted medical records, the request for psychological follow-up is not medically necessary.

One psychiatry consultation: Upheld

Claims Administrator guideline: Decision based on MTUS Stress-Related Conditions 2004.

MAXIMUS guideline: Decision based on MTUS Stress-Related Conditions 2004, Section(s): General Approach, Models and Definitions, Initial Assessment, Medical, Physical Examination, Diagnostic Testing, Treatment, Work-Relatedness, Follow-up, Failure, References.

Decision rationale: Per the CA MTUS ACOEM Medical Treatment Guidelines, specialty referrals may be necessary when patients have significant psychopathology or serious medical comorbidities. Some mental illnesses are chronic conditions, so establishing a good working relationship with the patient may facilitate a referral or the return-to-work process. It is recommended that serious conditions such as severe depression and schizophrenia be referred to a specialist, while common psychiatric conditions, such as mild depression, be referred to a specialist after symptoms continue for more than six to eight weeks. The practitioner should use his or her best professional judgment in determining the type of specialist. Issues regarding work stress and person-job fit may be handled effectively with talk therapy through a psychologist or other mental health professional. Patients with more serious conditions may need a referral to a psychiatrist for medicine therapy. In this case, the submitted medical records failed to provide documentation that the injured worker suffers from a serious condition such as severe depression or schizophrenia that would support a psychiatry consultation. Therefore, based on CA ACOEM guidelines and submitted medical records, the request for a psychiatry consultation is not medically necessary.