

Independent Medical Review Final Determination Letter

1084

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[REDACTED]
[REDACTED]
[REDACTED]

Dated: 12/30/2013

IMR Case Number:	CM13-0018481	Date of Injury:	05/08/2011
Claims Number:	[REDACTED]	UR Denial Date:	08/22/2013
Priority:	STANDARD	Application Received:	08/29/2013
Employee Name:	[REDACTED]		
Provider Name:	[REDACTED]		
Treatment(s) in Dispute Listed on IMR Application:			
PLEASE REFERENCE UTILIZATION REVIEW DETERMINATION LETTER			

DEAR [REDACTED]

MAXIMUS Federal Services has completed the Independent Medical Review (“IMR”) of the above workers’ compensation case. This letter provides you with the IMR Final Determination and explains how the determination was made.

Final Determination: PARTIAL OVERTURN. This means we decided that some (but not all) of the disputed items/services are medically necessary and appropriate. A detailed explanation of the decision for each of the disputed items/services is provided later in this letter.

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers’ Compensation. This determination is binding on all parties.

In certain limited circumstances, you can appeal the Final Determination. Appeals must be filed with the Workers’ Compensation Appeals Board within 30 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4610.6(h).

Sincerely,

Paul Manchester, MD, MPH
Medical Director

cc: Department of Industrial Relations, [REDACTED]

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation, and is licensed to practice in California. 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 physician 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/services.

DOCUMENTS REVIEWED

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]

CLINICAL CASE SUMMARY

The physician reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The underlying date of injury in this case is 05/08/2011. This patient is a 59-year-old man with chronic low back pain and recent shoulder surgery. The treating physician has reported the diagnoses of lumbar discopathy and status left shoulder arthroscopy with decompression.

The initial reviewer noted that the patient has been noted to have left shoulder pain with trouble with motion as well as a well-healed surgical scar and also tenderness and spasm in the mid to distal lumbar segments and radicular pain and dysesthesia in a right L5 distribution. The patient has been noted to be able to work in a modified duty capacity.

An initial physician reviewer concluded that naproxen was not medically necessary because the patient's symptoms appeared to remain unchanged and the patient had complaints of stomach upset due to long-term naproxen use. The physician reviewer indicated that omeprazole was not medically necessary because there was a lack of findings to show potential erosive lesions other than an upset stomach and the patient had no risk factors other than taking high doses of NSAIDs since 03/12/2012. Cyclobenzaprine was felt to be not medically necessary since it was only supported by the guidelines for a short time period. Ondansetron was felt to be not consistent with its FDA-approved indications, and also the physician reviewer noted that documents failed to indicate the reported nausea related to cyclobenzaprine. Regarding tramadol, the physician reviewer modified the request, noting that only a short course was indicated for trial. Regarding Medrox, the physician reviewer indicated that this treatment was not medically necessary as the indication for which it was used was not supported in the guidelines.

The treating physician's note of 05/20/2013 notes that the patient has reported pain relief from multiple medications.

IMR DECISION(S) AND RATIONALE(S)

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

1. The request for 120 Naproxen Sodium 550mg, DOS: 6/24/2013 is medically necessary and appropriate.

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines (2009), which is part of the MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines Section on Anti-inflammatory medication, which is part of the MTUS

The Physician Reviewer's decision rationale:

The Chronic Pain Medical Treatment Guidelines, section on anti-inflammatory medication, states, "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." An initial physician reviewer indicated that there were no specifically objectively documented benefits from this medication use; however, the treating physician does clearly indicate that the patient has reported symptomatic benefit from medications. While the treatment guidelines have very explicit requirements for objective functional improvement for drugs with significant potential for aberrant behavior such as opiates, there is no corresponding requirement for anti-inflammatory medications; the patient's reported subjective improvement in pain is sufficient to support indication for ongoing anti-inflammatory medication use. This drug does meet this guideline. This treatment is medically necessary.

2. The request for 120 Omeprazole DR 20 mg, DOS: 6/24/2013 is medically necessary and appropriate.

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines (2009), which is part of the MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines Section on Anti-inflammatory Medications and Gastrointestinal Symptoms, which is part of the MTUS.

The Physician Reviewer's decision rationale:

The Medical Treatment Utilization Schedule, section on anti-inflammatory and gastrointestinal symptoms, states, "Determine if the patient is at risk for gastrointestinal events: Age greater than 65 years; history of peptic ulcer, GI bleeding; concurrent use of aspirin or corticosteroids, or high dose/multiple NSAID."

The initial reviewer stated that since there is no clear evidence of erosive disease, gastrointestinal prophylaxis is not indicated. However, this guideline actually uses the determination of risk instead to stratify patients into no risk versus intermediate risk or high risk. Given this patient's history of gastroesophageal reflux on anti-inflammatory

medications, the guidelines recommend “nonselective NSAID with a proton pump inhibitor or misoprostol.” In this situation, the guidelines do support the request for omeprazole. This treatment is medically necessary.

3. The request for 120 Cyclobenzaprine Hydrochloride 7.5mg, DOS: 6/24/2013 is not medically necessary and appropriate.

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines (2009), which is part of the MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines Section on Muscle Relaxants, which is part of the MTUS.

The Physician Reviewer’s decision rationale: The Medical Treatment Utilization Schedule, section on muscle relaxants, states regarding cyclobenzaprine, “Recommended for a short course of therapy. Limited, mixed evidence does not allow for a recommendation for chronic use.” The medical records do not provide other rationale for utilizing this medication in a chronic setting. This medication is not medically necessary.

4. The request for 60 Ondansetron is not medically necessary and appropriate.

The Claims Administrator based its decision on the Official Disability Guidelines, Pain, (Chronic), which is not part of the MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines Section on Muscle Relaxants, which is part of the MTUS.

The Physician Reviewer’s decision rationale:

The Medical Treatment Utilization Schedule, section on muscle relaxants, states regarding cyclobenzaprine, “Recommended for a short course of therapy. Limited, mixed evidence does not allow for a recommendation for chronic use.” As noted in the initial physician review, the medical records do not clearly document nausea from cyclobenzaprine, which is the stated rationale for ondansetron. Moreover, cyclobenzaprine has been non-certified and therefore by that rationale there is no further indication for ondansetron. Furthermore, FDA-approved labeling information recommends ondansetron for chemotherapy-induced nausea or postoperative nausea but does not recommend it for chronic medication-induced gastrointestinal upset. For these reasons, this medication is not supported by the guidelines. This is not medically necessary.

5. The request for 90 Tramadol Hydrochloride ER 150mg, DOS: 6/24/2013 is medically necessary and appropriate.

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines (2009), which is part of the MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines Section on Tramadol, which is part of the MTUS.

The Physician Reviewer's decision rationale:

The Chronic Pain Medical Treatment Guidelines, section on tramadol, state this medication "Is not recommended as a first-line oral analgesic." The guidelines do not define a short course of tramadol as suggested by the first reviewer. Rather, in this case, the patient's ongoing gastrointestinal upset is a rationale for utilizing other than first-line analgesics in order to try to limit the use of medications causing side effects. Therefore, the medical records and the guidelines do support the use of tramadol. This treatment is medically necessary.

6. The request for two prescriptions of Medrox Ointment 120mg, DOS 6/24/2013 is not medically necessary and appropriate.

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines (2009), which is part of the MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines Section on Topical Analgesics, which is part of the MTUS.

The Physician Reviewer's decision rationale:

The Chronic Pain Medical Treatment Guidelines, section on topical analgesics, states, "The use of these compounded agents requires knowledge of the specific analgesic effect of each agent and how it will be useful for the specific therapeutic goal required." The medical records do not provide such information at this time in terms of a rationale for Medrox. This request is not supported by the guidelines. This medication is not medically necessary.

Disclaimer: MAXIMUS is providing an independent review service under contract with the California Department of Industrial Relations. MAXIMUS is not engaged in the practice of law or medicine. Decisions about the use or nonuse of health care services and treatments are the sole responsibility of the patient and the patient's physician. MAXIMUS is not liable for any consequences arising from these decisions.

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