MAXIMUS Federal Services

Case Number:	CM13-0010349		
Date Assigned:	06/06/2014	Date of Injury:	02/02/2001
Decision Date:	07/11/2014	UR Denial Date:	08/07/2013
Priority:	Standard	Application Received:	08/15/2013

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation has a subspecialty in Pain Medicine and is licensed to practice in Texas. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 53-year-old female who reported an injury on 02/02/2001 due to a slip and fall. An MRI dated 12/09/2013 revealed a transitional S1 vertebra, moderate facet arthropathy at L5-S1 with no central canal narrowing, facet arthropathy at L4-5 and L3-4, and a 3 mm biforaminal disc protrusion with abutment of the exiting right L5 nerve root. The clinical note dated 01/24/2014 noted the injured worker presented with continued knee buckling, pain in the left knee, right ankle, left shoulder, upper, mid, and low back, and hip pain. Examination of the left shoulder revealed tenderness over the subacromial region and posterior muscles, impingement and cross arm test elicited diffuse non-localized shoulder pain, and range of motion limited in all planes. There was tenderness over the paraspinal musculature with spasm and tenderness over the lumbosacral junction and a positive straight leg raise bilaterally. Prior treatment included aquatic therapy and medication. The diagnoses included lumbar spine sprain/strain with bilateral lower extremity radiculopathy, disc bulge at L4-5 and L5-S1 with disc degenerative disease, osteoarthritis at L5-S1, and osteoarthritis. The provider noted a retrospective request for omeprazole, tizanidine, hydrocodone, and trazodone.

IMR ISSUES, DECISIONS AND RATIONALES

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

RETROSPECTIVE REQUEST FOR 30 OMEPRAZOLE 20 MG (07/16/2013): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines GI Symptoms & Cardiovascular Events Page(s): 68-69.

Decision rationale: The California MTUS Guidelines recommend proton pump inhibitors for injured workers at risk for gastrointestinal events. The Guidelines recommend that clinicians utilize the following criteria to determine if the injured worker is at risk for gastrointestinal events to include age greater than 65 years old; history of peptic ulcer, GI bleeding or perforation; concurrent use of ASA, corticosteroid, and/or anticoagulants; and/or high dose multiple NSAID use. The medical documentation does not indicate the injured worker had gastrointestinal symptoms. It is not noted that the injured worker had a history of peptic ulcer, GI bleed, or perforation. It is not noted that the injured worker was at risk for gastrointestinal events. The frequency of the medication was not provided in the request as submitted. Therefore, the retrospective request for 30 Omeprazole 20 mg (07/16/2013) is not medically necessary.

RETROSPECTIVE REQUEST FOR 90 TIZANIDINE HCL 4 MG (07/16/2013): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants, for pain Page(s): 63-66.

Decision rationale: The California MTUS Guidelines recommend non-sedating muscle relaxants as a second line option for treatment of acute exacerbation of chronic low back pain. Efficacy appears to diminish over time, and prolonged use may lead to dependence. The provider noted the injured worker's medication regimen decreased pain and allowed the injured worker to perform activities of daily living; however, there is a lack of objective functional improvement noted in the documentation. There is a lack of a complete and adequate pain assessment for the injured worker. The frequency was not provided in the request as submitted. Therefore, the retrospective request for 90 Tizanidine HCL 4mg (07/16/2013) is not medically necessary.

RETROSPECTIVE REQUEST FOR 90 HYDROCODONE/APAP 7.5/750 MG (07/16/2013): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for use Page(s): 76-80.

Decision rationale: The California MTUS Guidelines recommend the use of opioids for ongoing management of chronic low back pain. The Guidelines recommend the ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. There is a lack of documentation of an objective assessment of the injured worker's pain level,

functional status, evaluation of risk for aberrant drug abuse behavior, and side effects. The request as submitted did not include the frequency of the medication. Therefore, the retrospective request for 90 Hydrocodone/APAP 7.5/750mg (07/16/2013) is not medically necessary.

RETROSPECTIVE REQUEST FOR 60 TRAZODONE HCL 50 MG (07/16/2013): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness & Stress, Trazodone.

Decision rationale: The Official Disability Guidelines recommend trazodone as an option for insomnia, only for injured workers with potentially co-existing mild psychiatric symptoms such as depression or anxiety. There is limited evidence to support its use for insomnia, but it may be an option in injured workers with co-existing depression. Other pharmacologic therapy should be recommended for primary insomnia before considering trazodone, especially if the insomnia is not accompanied by comorbid depression or recurrent treatment failure. There is no clear evidence to recommend trazodone to treat primary insomnia. An adequate examination of the injured worker was not provided detailing current sleep deficits to support the use of trazodone. There were no symptoms or diagnosis of insomnia, the severity of the insomnia was not addressed. It was not documented if the injured worker is having trouble with sleep onset, maintenance, quality of sleep, or next day functioning. The frequency of the medication was not provided in the request as submitted. Therefore, the retrospective request for 60 Trazodone HCL 50mg (07/16/2013) is not medically necessary.