

Case Number:	CM13-0063749		
Date Assigned:	12/30/2013	Date of Injury:	08/26/2009
Decision Date:	06/20/2014	UR Denial Date:	12/02/2013
Priority:	Standard	Application Received:	12/10/2013

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 Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in Florida. 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 23-year-old female who reported an injury on 08/26/2009. The injured worker was evaluated on 10/15/2013. It was documented that the injured worker underwent an epidural steroid injection on 08/19/2013 which provided approximately 2 weeks of pain relief. Physical findings included paravertebral tenderness to palpation at the L3-4 with negative straight leg raising test bilaterally and restricted range of motion secondary to pain. The injured worker's medications included Lyrica, Oxycodone, and Prilosec. This medication schedule had been consistent since at least 04/2013. The injured worker's diagnoses included lumbar disc disease with radiculopathy. The injured worker's treatment plan included modified work duty and continuation with medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

LYRICA 50MG #30 WITH TWO REFILLS: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
MEDICATIONS FOR CHRONIC PAIN; ANTIEPILEPSY DRUGS (AEDS) Page(s): 60;16.

Decision rationale: The requested Lyrica 50 mg #30 with 2 refills is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does recommend anticonvulsants as first line medications in the management of chronic pain. However, California Medical Treatment Utilization Schedule recommends continued use of medications in the management of chronic pain be supported by documentation of functional benefit and evidence of pain relief. The clinical documentation submitted for review does not provide an adequate assessment of pain relief or functional benefit related to medication usage to support continued use. Also, the request as it is submitted does not provide a frequency of treatment. Therefore, the appropriateness of the request itself cannot be determined. As such, the requested Lyrical 50 mg #30 with 2 refills is not medically necessary or appropriate.

OXYCODONE/APAP 10/325MG #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS; ON-GOING MANAGEMENT Page(s): 78.

Decision rationale: The requested Oxycodone/APAP 10/325 mg #30 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends the ongoing use of opioids in the management of chronic pain be supported by documentation of functional benefit, a quantitative assessment of pain relief, managed side effects, and evidence that the injured worker is monitored for aberrant behavior. The clinical documentation submitted for review fails to provide any evidence of an assessment of pain or documentation of functional benefit to support the efficacy of this medication. Additionally, there is no documentation that the injured worker is monitored for aberrant behavior. Also, the request as it is submitted does not provide a frequency of treatment. Therefore, the appropriateness of the request itself cannot be determined. As such, the requested Oxycodone/APAP 10/325 mg #30 is not medically necessary or appropriate.

PRILOSEC 20MG #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI SYMPTOMS & CARDIOVASCULAR RISK Page(s): 68.

Decision rationale: The requested Prilosec 20 mg #90 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends gastrointestinal protectant for patients who are at risk for developing gastrointestinal events related to medication usage. The clinical documentation submitted for review does not provide an adequate assessment of the injured worker's gastrointestinal system to support that the injured worker is at risk for developing gastrointestinal events secondary to medication usage. Therefore, ongoing use of this medication would not be supported. Also, the request as it is submitted does not contain a

frequency of treatment. Therefore, the appropriateness of the request itself cannot be determined. As such, the requested Prilosec 20 mg #90 is not medically necessary or appropriate.

ZOFRAN 8MG #20: 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) PAIN CHAPTER, ANTI-EMETICS.

Decision rationale: The requested Zofran 8 mg #20 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not address the use of antiemetics. Official Disability Guidelines do not support the use of antiemetics to offset nausea and vomiting complaints related to medication usage. Therefore, the need for Zofran is not supported. Additionally, the request as it is submitted does not identify a frequency of treatment. Therefore, the appropriateness of the request itself cannot be determined. As such, the requested Zofran 8 mg #20 is not medically necessary or appropriate.