

Case Number:	CM14-0008150		
Date Assigned:	02/12/2014	Date of Injury:	10/19/2000
Decision Date:	07/25/2014	UR Denial Date:	12/26/2013
Priority:	Standard	Application Received:	01/22/2014

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 Sports 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 70 year old female who reported an injury on 10/19/2000 after a fall. The injured worker reportedly sustained an injury to her neck, bilateral knees, low back and thoracic spine. The injured worker ultimately underwent L4-5 and L5-S1 fusion in 2004. The injured worker developed chronic pain related to her injury that was managed with multiple medications. The injured worker was monitored for aberrant behavior with urine drug screens. The injured worker was evaluated on 10/07/2013. It was noted that the injured worker required C-Difficile in the hospital and continued to suffer from severe back pain. The injured worker was again evaluated on 02/05/2014. It is documented that the injured worker was seeing a pain management specialist for medication management. However, no documentation from that provider was submitted for review. A request was made for multiple medications, peripheral stimulation therapy, followup with an orthopedist, and followup with an orthopedic spine surgeon and a left trochanteric bursas injection. No justification for the request was provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

FENTORA 400UGM QTY: 28.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 79-124.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS, ON-GOING MANAGEMENT Page(s): 77.

Decision rationale: The MTUS Chronic Pain Guidelines recommends the ongoing use of a fentanyl patch be supported by documented functional benefit, a quantitative assessment of pain relief, and side effects and evidence that the injured worker is monitored for aberrant behavior. There was no clinical documentation from the requesting physician to support the ongoing use of this medication. Furthermore, the request as submitted does not provide a frequency of treatment. In the absence of this information, the appropriateness of the request cannot be determined. As such, the request is not medically necessary and appropriate.

ZOFRAN 4 MG QTY: 30.00: 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 Official Disability Guidelines recommend this medication for acute gastritis. However, there is no documentation from the requesting provider to support the request. Therefore, the necessity of this medication cannot be determined. Furthermore, the request as it is submitted does not clearly identify a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. The request is not medically necessary and appropriate.

LACTULOSE (DOSAGE /QUANTITY UNSPECIFIED) QTY: 1.00: 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 INITIATING THERAPY Page(s): 77.

Decision rationale: The MTUS Chronic Pain Guidelines does recommend the prophylactic treatment of constipation when opioids are used to manage chronic pain. However, there was no clinical documentation from the requesting provider to support this request. Therefore, the appropriateness of this medication cannot be determined. Furthermore, the request as it is submitted does not provide a dosage, quantity or frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the request is not medically necessary and appropriate.

CYMBALTA 30 MG (QUANTITY UNSPECIFIED) QTY: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 43.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ANTI-DEPRESSANTS FOR CHRONIC PAIN Page(s): 13.

Decision rationale: The MTUS Chronic Pain Guidelines does recommend antidepressants as a first line medication in the management of chronic pain. However, there was no clinical documentation submitted for review from the requesting provider to justify the request. Furthermore, the request as it is submitted does not clearly define a quantity or frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the request is not medically necessary and appropriate.

LYRICA (DOSAGE/QUANTITY UNSPECIFIED) QTY: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ANTI-EPILEPTIC MEDICATION FOR CHRONIC PAIN Page(s): 16.

Decision rationale: The MTUS Chronic Pain Guidelines does recommend anticonvulsants as a first line medication in the management of chronic pain. However, there was no documentation submitted for review from the treating physician. In the absence of this information, the appropriateness of this medication cannot be determined. Additionally, the request as it is submitted, does not clearly define a dosage, quantity or frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the request is not medically necessary and appropriate.

SENOKOT-S (DOSAGE/QUANTITY UNSPECIFIED) QTY: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 77.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS, INITIATING TREATMENT Page(s): 77.

Decision rationale: The MTUS Chronic Pain Guidelines does recommend the prophylactic treatment of constipation when opioids are used to manage chronic pain. However, there was no clinical documentation from the requesting provider to support this request. Therefore, the appropriateness of this medication cannot be determined. Furthermore, the request as it is submitted does not provide a dosage, quantity or frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the request is not medically necessary and appropriate.

PERIPHERAL STIM THERAPY QTY: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 89.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines SYMPATHETIC THERAPY Page(s): 121.

Decision rationale: The MTUS Chronic Pain Guidelines does not recommend sympathetic therapy as it is considered investigational. The clinical documentation submitted for review did not provide a justification from the treating provider to support extending treatment beyond guideline recommendations. Additionally, the request as submitted does not clearly define a quantity, frequency or body part. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested peripheral stimulation therapy is not medically necessary and appropriate.

FOLLOW UP WITH ORTHOPEDIST QTY: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 89.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation 163.

Decision rationale: The requested followup with an orthopedist is not medically necessary or appropriate. The ACOEM Guidelines does indicate that specialists can manage treatment. However, the clinical documentation submitted for review did not provide any information from the treating physician to support the request. As such, the requested followup with an orthopedist quantity 1 is not medically necessary or appropriate.

FOLLOW UP WITH ORTHOPEDIC SPINE SURGEON QTY: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 89.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation 163.

Decision rationale: The requested followup with an orthopedic spine surgeon is not medically necessary or appropriate. The ACOEM Guidelines does indicate that specialists can manage treatment. However, the clinical documentation submitted for review did not provide any information from the treating physician to support the request. As such, the requested followup with an orthopedic spine surgeon quantity 1 is not medically necessary or appropriate.

LEFT TROCHANTERIC BURSA INJECTION QTY: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

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

Decision rationale: The Official Disability Guidelines do recommend trochanteric bursitis injections. However, there was no documentation submitted from the requesting physician to support the request. As such, the requested left trochanteric bursa injection quantity 1 is not medically necessary or appropriate.