MAXIMUS Federal Services

Case Number:	CM14-0106756		
Date Assigned:	07/30/2014	Date of Injury:	09/10/2008
Decision Date:	10/23/2014	UR Denial Date:	06/17/2014
Priority:	Standard	Application Received:	07/10/2014

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 & Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Texas and Oklahoma. 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 40-year-old female who reported an injury on 09/10/2008. The mechanism of injury was not submitted for clinical review. The diagnosis included status post release of right carpal tunnel syndrome, mild to moderate bilateral carpal tunnel syndrome, ulnar nerve entrapment at the left elbow, mild to moderate bilateral radiculopathy, chronic myofascial pain syndrome, and chronic daily headaches. The previous treatments included medication, trigger point injections, and surgery. Within the clinical note dated 07/15/2014, it was reported the injured worker complained of pain and numbness in the right arm, elbow, and hand. She reported constant upper and lower back pain. She rated her pain 5/10 to 8/10 in severity. Upon the physical examination, the provider noted the range of motion of the thoracic and lumbar spine was mildly restricted in all planes. There was palpable tenderness noted in the lateral aspect of the right wrist, as well as to the medial epicondyle area. Sensation to fine touch and pinprick was decreased in all digits of the bilateral hand, as well as the bilateral lower extremities. The provider requested omeprazole for gastritis, mirtazapine for chronic pain and insomnia, topiramate for vascular headaches, and tramadol for pain. The Request for Authorization was not submitted for clinical review.

IMR ISSUES, DECISIONS AND RATIONALES

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

RETRO Omeprazole 20mg BID #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines GI symptoms & cardiovascular risk Page(s): 68-69.

Decision rationale: The retrospective request for omeprazole 20 mg twice a day #90 is not medically necessary. The California MTUS Guidelines note proton pump inhibitors such as omeprazole are recommended for injured workers at risk for gastrointestinal events and/or cardiovascular disease. The risk factors for gastrointestinal events include over the age of 65; history of peptic ulcers, gastrointestinal bleeding or perforation; use of corticosteroids, and/or anticoagulants. In the absence of risk factors for gastrointestinal bleeding events, proton pump inhibitors are not indicated when taking NSAIDs. The treatment of dyspepsia from NSAID usage includes stopping the NSAID, switching to a different NSAID, or adding an H2 receptor antagonist or proton pump inhibitor. There is a lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. There is a lack of clinical documentation indicating the injured worker had a diagnosis of dyspepsia secondary to NSAID therapy. Therefore, the request is not medically necessary.

RETRO Mirtazapine 15mg #90: 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 Antidepressants Page(s): 13.

Decision rationale: The retrospective request for mirtazapine 15 mg #90 is not medically necessary. The California MTUS Guidelines recommend antidepressants as a first line option for neuropathic pain, and as a possibility for non neuropathic pain. There is a lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. Therefore, the request is not medically necessary.

RETRO Topiramate 50mg #90: 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 Antiepiliespy drugs (AED) Page(s): 16; 21.

Decision rationale: The retrospective request of topiramate 50 mg #90 is not medically necessary. The California MTUS Guidelines recommend topiramate for neuropathic pain. The guidelines note the medication has been shown to have variable efficacy, with failure to demonstrate efficacy on neuropathic pain and central etiology. It is still considered for the use of

neuropathic pain when other anticonvulsants have failed. After initiation of the treatment, there should be documentation of pain and improvement in function, as well as documentation of side effects incurred with use. The guidelines note the continued use of antiepilepsy drugs on improved outcomes versus tolerability to adverse effects. There is a lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. Therefore, the request is not medically necessary.

RETRO Tramadol HCL ER 150mg #45: 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, On-Going Management Page(s): 78.

Decision rationale: The retrospective request for tramadol HCl ER 130 mg #45 is not medically necessary. The California MTUS Guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The guidelines recommend the use of a urine drug screen or inpatient treatment with issues of abuse, addiction, or poor pain control. There is a lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. Additionally, the use of a urine drug screen was not submitted for clinical review. The provider failed to document an adequate and complete pain assessment within the documentation. Therefore, the request is not medically necessary.