MAXIMUS Federal Services

Case Number:	CM14-0076539		
Date Assigned:	07/18/2014	Date of Injury:	12/15/2006
Decision Date:	09/16/2014	UR Denial Date:	04/30/2014
Priority:	Standard	Application Received:	05/27/2014

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 and is licensed to practice in Illinois. 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 56-year-old female who reported an injury on 12/15/2006. The mechanism of injury was not provided for review. The injured worker reportedly sustained an injury to her neck and knee. The injured worker underwent a total knee arthroplasty followed by postoperative physical therapy. The injured worker's chronic pain was managed with medications. The injured worker was evaluated on 04/02/2014. It was documented that the injured worker's pain was managed with medications that allowed for increased daily function. Physical examination findings included tenderness and spasming noted in the paravertebral musculature of the cervical spine with restricted range of motion secondary to pain. It was noted that there was tenderness to the right knee. The injured worker's diagnoses included cervical sprain/strain, chronic pain, status post knee replacement, comminuted fracture of the right radius, status post joint replacement of the right elbow. It was noted that prior attempts of weaning the injured worker's medications caused a severe increase in pain and reduction in functional activities. The injured worker's treatment plan included a urine drug screen and continued medications to include Gabapentin, Glucosamine, Hydrocodone, Pantoprazole, Tizanidine, Cartivisc and Tramadol. A Request for Authorization to refill medications was submitted on 04/23/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective Urine drug screen DOS 04/02/2014: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Drug Testing Page(s): 53.

Decision rationale: The requested retrospective urine drug screen on 04/02/2014 is not medically necessary or appropriate. The clinical documentation submitted for review does indicate that the injured worker underwent a urine drug screen in 11/2013. The previous drug screen was consistent with the injured worker's medication schedule. The clinical documentation submitted for review for 04/02/2014 did not provide any evidence of aberrant behavior. There were no symptoms of overuse or underuse to support the need for evaluation for aberrant behavior. California Medical Treatment Utilization Schedule does recommend evaluation for aberrant behavior with urine drug screens. However, Official Disability Guidelines recommend low risk patients be monitored on a yearly basis. Therefore, an additional urinalysis would not be supported at this time. As such, the requested retrospective urine drug screen for date of service 04/02/2014 is not medically necessary.

Retrospective Hydrocodone / APAP 10/325mg #120 DOS 04/02/2014: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-Going Management Page(s): 78.

Decision rationale: The retrospective request for Hydrocodone/APAP 10/325 mg #120 for date of service 04/02/2014 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 documented functional benefit, a quantitative assessment of pain relief, evidence that the patient is monitored for aberrant behavior, and managed side effects. The clinical documentation submitted for review does indicate that the injured worker underwent a urine drug screen in 11/2013 that was consistent with the injured worker's prescribed medication schedule. However, the documentation from 04/02/2014 did not provide a quantitative assessment of pain relief to support the efficacy of this medication. Additionally, increased functionality due to the use of medication was not provided. Therefore, ongoing use of this medication would not be supported. Furthermore, the request as it is submitted does not clearly identify a frequency of treatment. In absence of this information the appropriateness of the request itself cannot be determined. As such, the retrospective request for hydrocodone/APAP 10/325 mg #120 for date for date of service 04/02/2014 is not medically necessary or appropriate.

Retrospective Tizanidine 4mg #60 DOS 04/02/2014: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ANTISPASTICITY / ANTISPASMODIC DRUGS: Tizanidine (Zanaflex).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63.

Decision rationale: The retrospective request for Tizanidine 4 mg #60 for date of service 04/02/2014 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not recommend the long term use of muscle relaxants in the management of chronic pain. California Medical Treatment Utilization Schedule limits the use of muscle relaxants to 2 to 3 weeks for acute exacerbations of chronic pain. The clinical documentation indicates that the injured worker has been on this medication for a duration to exceed this recommendation. Therefore, continued use would not supported. 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. As such, the retrospective request for Tizanidine 4mg #60 date of service 04/02/2014 is not medically necessary or appropriate.

Retrospective Pantoprazole 20mg #30 DOS 04/02/2014.: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk.

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

Decision rationale: The retrospective request for Pantoprazole 20 mg #30 for date of service 04/02/2014 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends gastrointestinal protectants for injured workers 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 they are at risk for development of gastrointestinal disturbances related to medication usage. Therefore, ongoing use of this medication would not be supported. Furthermore, the request as it is submitted does not provide frequency of treatment. In the absence of this information the appropriateness of the request itself cannot be determined. As such, the retrospective request for pantoprazole 20 mg #30 for date of service 04/02/2014 is not medically necessary.

Retrospective Tramadol 50mg #60 DOS 04/02/2014: 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, On-Going Management Page(s): 78.

Decision rationale: The retrospective request for Tramadol 50 mg #60 date of service 04/02/2014 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 documented functional benefit, a quantitative assessment of pain relief, evidence that the patient is monitored for aberrant behavior, and managed side effects. The clinical documentation submitted for review does indicate that the injured worker underwent a urine drug screen in 11/2013 that was consistent with the injured worker's prescribed medication schedule. However, the documentation from 04/02/2014 did not provide a quantitative assessment of pain relief to support the efficacy of this medication. Additionally, increased functionality due to the use of medication was not provided. Therefore, ongoing use of this medication would not be supported. Furthermore, the request as it is submitted does not clearly identify a frequency of treatment. In absence of this information the appropriateness of the request itself cannot be determined. As such, the retrospective request for Tramadol 50 mg #60 date for date of service 04/02/2014 is not medically necessary or appropriate.

Retrospective Cartivisc 500-150-200mg #90 DOS 04/02/2014: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Glucosamine (and Chondroitin Sulfate).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Glucosamine (and Chondroitin Sulfate) Page(s): 50.

Decision rationale: The requested Cartivisc 500/150/200 mg #90 for date of service 04/02/2014 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does recommend the use of glucosamine in the management of osteoarthritic joint pain. However, California Medical Treatment Utilization Schedule recommends that all medications used in the management of chronic pain be supported by documented functional benefit and evidence of pain relief. The clinical documentation submitted for review from date of service 04/02/2014 does not provide an adequate assessment of the injured worker's pain relief to support continuation of the use of this medication. Additionally, there was no documentation of significant functional benefit related to medication usage. 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. As such, the retrospective request for cartivisc 500/150/200 mg #90 date of service 04/02/2014 is not medically necessary or appropriate.