

Case Number:	CM14-0088269		
Date Assigned:	08/06/2014	Date of Injury:	01/11/2006
Decision Date:	10/10/2014	UR Denial Date:	05/12/2014
Priority:	Standard	Application Received:	06/12/2014

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 California. 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 44-year-old male who reported an injury on 01/11/2006 due to an unknown mechanism. Diagnoses were chronic myofascial pain syndrome, thoracolumbar spine, bilateral L5 and right S-1 radiculopathy. Past treatment was trigger point injections. Diagnostics were EMG. Past surgical history was not reported. Physical examination on 02/25/2014 revealed complaints of intermittent pain and numbness in the bilateral lower extremities. Examination revealed ranges of motion in the thoracic spine were slightly restricted in all planes while the ranges of motion of the lumbar spine were slightly too moderately restricted in all planes. There were multiple myofascial trigger points and taut bands noted throughout the thoracic and paraspinal musculature, as well as in the gluteal muscles. Sensation to touch and pinprick was decreased in the posterior aspect of the right thigh and calf, as well as in the dorsum and plantar surfaces of the right foot. Dorsiflexion was decreased at -5/5 in the right foot. Ankle jerks were absent bilaterally. Treatment plan was to take medications as directed. Also, to continue home exercises. The Request for Authorization was not submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tramadol HCL ER 150mg #45: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): page 80.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol; Ongoing Management Page(s): 82, 93, 94, 113.

Decision rationale: The request for Tramadol HCL ER 150 mg quantity 45 is not medically necessary. The California Medical Treatment Utilization Schedule states central analgesic such as Tramadol (Ultram) was reported to be effective in managing neuropathic pain and is not recommended as a first line oral analgesic. The guidelines recommend that there should be documentation of the 4 A's for ongoing monitoring, including analgesia, activities of daily living, adverse side effects, and aberrant drug taking behavior. The efficacy of this medication was not reported. Also, the request does not indicate a frequency for the medication. Therefore, the request is not medically necessary.

Naproxen 550mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): page 67.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anaprox (Naproxen) Page(s): 72.

Decision rationale: The request for naproxen 550 mg quantity 120 is not medically necessary. The California Medical Treatment Utilization Schedule Guidelines indicate that naproxen is a non-steroidal anti-inflammatory drug (an NSAID) for the relief of the signs and symptoms of osteoarthritis and they recommend the lowest effective dose be used for all NSAIDs for the shortest duration of time consistent with the individual patient treatment goals. The efficacy of this medication was not reported. Also, the request does not indicate a frequency for the medication. Therefore, the request is not medically necessary.

Hydrocodone/APAP 5/325mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): page 80.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Ongoing Management; Hydrocodone/Acetaminophen Page(s): 78; 91.

Decision rationale: The request for Hydrocodone/APAP 5/325 mg quantity 120 is not medically necessary. The California Medical Treatment Utilization Schedule recommends that there should be documentation of the 4 A's for ongoing monitoring including analgesia, activities of daily living, adverse side effects, and aberrant drug taking behavior. It further notes that dosing of opioids not exceed 120 mg or a morphine equivalence per day, and for patients taking more than 1 opioid, the morphine equivalent doses of the different opioids must be added together to determine accumulative dose. The efficacy of this medication was not reported. Also, the request does not indicate a frequency for the medication. Therefore, the request is not medically necessary.

Deep Breathing Meditation CD: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): page 301.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: The decision for Deep Breathing Medication CD is not addressed by The California Medical Treatment Utilization Schedule, ACOEM or Official Disability Guidelines. A name for the medication must be submitted. Therefore, the decision for Deep Breathing Medication CD is not medically necessary.