

Case Number:	CM14-0092041		
Date Assigned:	07/25/2014	Date of Injury:	08/08/2002
Decision Date:	09/23/2014	UR Denial Date:	05/28/2014
Priority:	Standard	Application Received:	06/18/2014

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 60-year-old male who reported an injury on 08/08/2002. The mechanism of injury was not provided. He had diagnoses of cervical herniated nucleus pulposus (HNP) C6-7, cervical radiculopathy C6-7, cervical spondylosis with myelopathy bilaterally, lumbar herniated disc L5-S1 and L4-5, lumbar radiculopathy L5 and S1, lumbar spondylosis, impingement rotator cuff tendinitis left, rotator cuff tear left, and superior labrum anterior posterior (SLAP) lesion type I. Past treatments include an exercise regimen and medications. The diagnostic studies and surgical history were not provided. The information received was a handwritten note from the injured worker and the utilization review documentation. No other clinical notes were provided. On 06/14/2014, the injured worker hand wrote a letter concerning his medication refill. The injured worker stated that his pain has always been a 4 and as high as a 6 with the medications. He never had shots in neck even though they were approved. The last shot he received was in 2011 for the neck. The last shot he received for the lower back was in 02/2014. The injured worker has atrophy in the left leg and left arm. The injured worker stated he had a history of Gastroesophageal reflux disease (GERD). The injured worker stated his problem was chronic, long term, and he had life time medical through Workman's Comp. He does not understand why everything was being disputed that his provider ask for. There was no treatment plan. The request is for hydrocodone/ acetaminophen 5/325 #120 with 2 refills 05/19/2014 through 08/20/2014, ranitidine HCL 150 mg #60 with 2 refills 05/19/2014 through 08/20/2014, tramadol 50 mg #240 with 2 refills 05/19/2014 through 08/20/2014, and Percocet 10/325 mg #180 from 05/19/2014 through 07/21/2014. The rationale and Request for Authorization were not provided within the documentation submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hydrocodone/ Acetaminophen 5/325mg #120 with 2 refills (05/19/2014 - 08/20/2014):
Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids
Page(s): 78, 91.

Decision rationale: The injured worker has a history of chronic pain. The California MTUS Guidelines state that Norco/ hydrocodone/acetaminophen is a short acting opioid which is an effective method in controlling chronic, intermittent or breakthrough pain. The guidelines recognize 4 domains that have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non-adherent) drug-related behaviors. The injured worker was receiving hydrocodone and Percocet. There is a lack of quantifiable functional improvement. There is a lack of documentation of moderate to severe pain. There is a lack of frequency provided within the request. There is lack of documentation addressing the four domains. As such, Hydrocodone/ Acetaminophen 5/325mg #120 with 2 refills (05/19/2014 - 08/20/2014) is not medically necessary.

Ranitidine Hcl 150mg #60 with 2 refills (05/19/2014 - 08/20/2014): Upheld

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

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

Decision rationale: The injured worker has a history of chronic pain. Ranitidine is classified as a H2-receptor antagonist. The MTUS Guidelines recommend consideration of H2-receptor antagonists for the treatment of dyspepsia secondary to NSAID therapy. There is a lack of documentation of Gastroesophageal complaints or symptoms. As such, there is no medical necessity for said medication. There is a lack of documentation as to the frequency provided within the request. As such, Ranitidine Hcl 150mg #60 with 2 refills (05/19/2014 - 08/20/2014) is not medically necessary.

Tramadol 50mg #240 with 2 refills (05/19/2014 - 08/20/2014): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic pain Page(s): 113.

Decision rationale: The injured worker has a history of chronic pain. The MTUS guidelines state tramadol (Ultram) is a centrally acting synthetic opioid analgesic and it is not recommended as a first line oral analgesic. There is an increased risk of seizure with taking tramadol. There is a lack of documentation of evidence of objective pain and functional improvement. There is a lack of documentation of moderate to severe pain. There is a lack of documentation as to the necessity for the need of 2 opioids at this time. There is a lack of documentation of medical necessity for said medication. There is a lack of documentation of the frequency on the request. As such, Tramadol 50mg #240 with 2 refills (05/19/2014 - 08/20/2014) is not medically necessary.

Percocet 10/325mg #180 (05/19/2014 - 07/21/2014): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic pain, Percocet Ongoing Management Page(s): 75, 78, 86.

Decision rationale: The injured worker has a history of chronic pain. The MTUS Guidelines recommend Oxycodone/Acetaminophen (Percocet) for moderate to severe chronic pain, and state 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 is further recommend that dosing of opioids not exceed 120 mg oral morphine equivalents per day, and for patients taking more than 1 opioid, the morphine equivalent doses of the different opioids must be added together to determine the cumulative dose. Percocet is a combination of oxycodone and acetaminophen. This is also another opioid analgesic. Opioids are not recommended as a first line of treatment. There is a lack of documentation of objective pain and functional improvement. There is a lack of documentation of adverse reaction or side effects from said medicine. There is a lack of documentation of the frequency within the request. As such, Percocet 10/325mg #180 (05/19/2014 - 07/21/2014) is not medically necessary.