

Case Number:	CM14-0194153		
Date Assigned:	12/02/2014	Date of Injury:	08/29/2011
Decision Date:	01/14/2015	UR Denial Date:	11/19/2014
Priority:	Standard	Application Received:	11/19/2014

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 Anesthesiology, has a subspecialty in Pain Management 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:

According to the records made available for review, this is a 57-year-old male with an 8/29/11 date of injury, and status post L5-S1 surgery 5/13 and status post L4-5 and L5-S1 fusion 3/24/14. At the time (11/19/14) of request for authorization for retro: Tramadol ER 150mg #30 30 day supply, retro: Fenopropfen Calcium 400mg #30, 30 day supply, retro: Omeprazole 20mg #30 30 day supply, and retro: Hydrocodone/APAP 2.5/325mg 30, 30 day supply, there is documentation of subjective (more pain due to possible hardware moving, weakness of legs, dysesthesia pain in the right more than left) and objective (bilateral tenderness and spasms of the L3-5 paraspinals, pain with extension of the back, pain with palpation of the sacroiliac joints, positive Faber sign, decreased lumbar spine range of motion, decreased sensory along the right lateral leg) findings, current diagnoses (lumbar disc disease, and lumbar radiculopathy), and treatment to date (physical therapy, activity modification, and medications (including Ketoprofen cream, Tramadol ER, Hydrocodone/APAP, Lidocaine patch, Theramine, Sentra PM and Sentra AM)). 10/9/14 medical report identifies medications are helpful to control pain. In addition, 10/9/14 medical report identifies that medications side effects were discussed and a urine drug screen was performed. Furthermore, 10/9/14 medical report identifies that Prilosec is prescribed to treat gastritis from NSAIDs. Regarding the requested retro: Tramadol ER 150mg #30 30 day supply, there is no documentation that the prescriptions are from a single practitioner and that the lowest possible dose is being prescribed, and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a specific result of Tramadol ER use to date. Regarding the requested retro: Omeprazole 20mg #30 30 day supply, there is no documentation of subjective/objective findings consistent with gastritis and/or risk for gastrointestinal event. Regarding the requested retro: Hydrocodone/APAP 2.5/325mg 30, 30 day supply, there is no documentation that the

prescriptions are from a single practitioner and that the lowest possible dose is being prescribed and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a specific result of Hydrocodone/APAP use to date.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retro: Tramadol ER 150mg #30 30 day supply: 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 Page(s): 74-80. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines necessitate documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects, as criteria necessary to support the medical necessity of opioids. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of lumbar disc disease, and lumbar radiculopathy. In addition, there is documentation of ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. However, there is no documentation that the prescriptions are from a single practitioner and that the lowest possible dose is being prescribed. In addition, given medical records reflecting ongoing use of Tramadol ER and despite documentation that medications are helpful to control pain, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a specific result of Tramadol ER use to date. Therefore, based on guidelines and a review of the evidence, the request for retro Tramadol ER 150mg #30 30 day supply is not medically necessary.

Retro: Fenoprofen Calcium 400mg #30, 30 day supply: Overturned

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 NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 67-68. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of moderate to severe osteoarthritis pain, acute low back pain, chronic low back pain, or exacerbations of chronic pain, as criteria necessary to support the medical necessity of NSAIDs. Within the medical information available for review, there is documentation of diagnoses of lumbar disc disease, and lumbar radiculopathy. In addition, there is documentation of chronic low back pain. Therefore, based on guidelines and a review of the evidence, the request for retro Fenoprofen Calcium 400mg #30, 30 day supply is medically necessary.

Retro: Omeprazole 20mg #30 30 day supply: 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. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), Proton pump inhibitors (PPIs)

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies that risk for gastrointestinal event includes age > 65 years; history of peptic ulcer, GI bleeding or perforation; concurrent use of ASA, corticosteroids, and/or an anticoagulant; and/or high dose/multiple NSAID. ODG identifies documentation of risk for gastrointestinal events, preventing gastric ulcers induced by NSAIDs, as criteria necessary to support the medical necessity of Omeprazole. Within the medical information available for review, there is documentation of diagnoses of lumbar disc disease, and lumbar radiculopathy. However, despite documentation that Prilosec is being prescribed to treat gastritis from NSAIDs, there is no documentation of subjective/objective findings consistent with gastritis and/or risk for gastrointestinal event. Therefore, based on guidelines and a review of the evidence, the request for retro Omeprazole 20mg #30, 30 day supply is not medically necessary.

Retro: Hydrocodone/APAP 2.5/325mg 30, 30 day supply: 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 Page(s): 74-80. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines necessitate documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects, as criteria necessary to support the medical necessity of opioids. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is

documentation of diagnoses of lumbar disc disease, and lumbar radiculopathy. In addition, there is documentation of ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. However, there is no documentation that the prescriptions are from a single practitioner and that the lowest possible dose is being prescribed. In addition, given medical records reflecting ongoing use of Hydrocodone/APAP and despite documentation that medications are helpful to control pain, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a specific result of Hydrocodone/APAP use to date. Therefore based on guidelines and a review of the evidence the request for retro Hydrocodone/APAP 2.5/325mg 30, 30 day supply is not medically necessary.