MAXIMUS Federal Services

Case Number:	CM15-0001293		
Date Assigned:	01/12/2015	Date of Injury:	10/19/2011
Decision Date:	03/06/2015	UR Denial Date:	12/12/2014
Priority:	Standard	Application Received:	01/05/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: California
Certification(s)/Specialty: Emergency Medicine

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This 42 year old female sustained an industrial injury on 10/19/11. Mechanism of injury is described as a slip and fall sustaining injury to her low back and left ankle. Patient has a diagnosis of Sciatica, lumbar disc displacement, L ankle injury with injury post L ankle split rupture of peroneus brevis tendon post repair, arthrofibrosis synovitis with lateral impingement post repair and gait instability. Ankle surgery was done on 9/15/14.Medical reports reviewed. Last report available until 1/5/15. Patient complains of L ankle pain and antalgic gait. Pain is 2/10, increasing to 4/10 when weight bearing. Using a cam walker boot. Objective exam is listed as decreased range of motion to ankle and irritability. Mild edema to site. Pain with ROM. Scar is well healed. Strength and sensory exam is normal. Normal pulses. Patient has reported back pain with positive straight leg raise on L side with spasms and guarding on back exam. Letter of appeal dated 12/15/14 was reviewed. It states that Seroqual was prescribed for insomnia and is reportedly "sleeping better". Pantoprazole is for GERD and is reportedly effective. It mentions prior use of NSAIDs but there is no note as to whether ongoing NSAID therapy was continuing. Tramadol was for retro prescription but has otherwise discontinued the medication. All progress notes do not report any NSAID as current medications. The injured worker has undergone MRI's, chiropractic care and surgery of the left ankle. Patient has undergone 12 sessions of physical therapy.Current medications include Protonix, Tramadol, Seroquel, Neurontin, Prilosec and Zoloft. The UR decision dated 12/12/14 non-certified Pantoprazole- Protonix 20 MG #60 DOS 11/04/2014, Tramadol/ APAP 37.5/325 #90 DOS 11/04/2014 and Quetiapine Femarate- Seroquel 25 MG #60 DOS 11/04/2014. The Pantoprazole- Protonix 20 MG #60 DOS

11/04/2014, Tramadol/ APAP 37.5/325 #90 DOS 11/04/2014 and Quetiapine Femarate-Seroquel 25 MG #60 DOS 11/04/2014 medications were not certified based on the lack of clear indications in the MTUS, CURES and ODG guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective request for Pantoprazole- Protonix 20 Mg #60 Dos 11/04/2014: 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 NSAIDs, GI symptoms and cardiovascular risks Page(s): 68-69.

Decision rationale: Protonix is a proton-pump inhibitor used for dyspepsia from NSAID use or gastritis/peptic ulcer disease. As per MTUS guidelines, PPIs may be used in patients with high risk for gastric bleeds or problems or signs of dyspepsia on NSAID therapy. The documentation concerning the patient does not meet any high risk criteria to warrant PPIs. Patient has complaints of dyspepsia and acid reflux but is not noted to be on any NSAIDs on the last several progress notes. MTUS guidelines recommends treatment with PPI in relation to NSAID use only. If patient has GERD at baseline, NSAIDs should be discontinued. Documentation fails to support Protonix prescription as per MTUS guidelines. Protonix is not medically necessary.

Retrospective request for Tramadol/ Apap 37.5/325 #90 Dos 11/04/2014: 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 Page(s): 76-78.

Decision rationale: Tramadol/Ultram is a Mu-agonist, an opioid-like medication. This medication also contains acetaminophen/APAP. As per MTUS Chronic pain guidelines, documentation requires appropriate documentation of analgesia, activity of daily living, adverse events and aberrant behavior. Documentation fails to meets the appropriate documentation required by MTUS. There is no documentation of pain improvement, no appropriate documentation of objective improvement in pain or function with current therapy as per MTUS guideline criteria. There is appropriate documentation of monitoring in letter of appeal but the documentation concerning any benefit from the medication fails guideline requirements. Documentation fails MTUS guidelines for chronic opioid use. Tramadol/APAP is not medically necessary.

Retrospective request for Quetiapine Femarate- Seroquel 25 Mg #60 Dos 11/04/2014: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Pain(Chronic)

Decision rationale: There is no specific sections in the MTUS chronic pain or ACOEM guidelines that relate to this topic. Quetiapine/Seroquel is an atypical antipsychotic and is not FDA approved for Insomnia. As per ODG guidelines, it recommends treatment of underlying cause of sleep disturbance and recommend short course of treatment. Seroquel is an off label use of a medication that is not recommended by the ODG for the treatment of insomnia. There are no documented improvement or conservative measures attempted. Seroquel is not medically necessary.