

Case Number:	CM15-0004370		
Date Assigned:	01/15/2015	Date of Injury:	03/24/2012
Decision Date:	04/07/2015	UR Denial Date:	12/31/2014
Priority:	Standard	Application Received:	01/08/2015

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: New York

Certification(s)/Specialty: Internal 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:

The injured worker is a 57-year-old female who sustained an industrial injury on 03/24/2012. Diagnoses include C5-C6 and C6-C7 disc degeneration, left cervical radiculopathy, and left shoulder impingement. Treatment to date has included medications, and epidural steroid injections. A physician progress note dated 07/18/2014 documents the injured worker has pain in the neck, shoulder, pain that goes down both arms, left more than right and her pain is rated as 4-5 out of 10. The cervical spine has tenderness to palpation on the left cervical paraspinal, occipital region and into the trapezius and interscapular space. Range of motion is decreased. There is decreased sensation from C5 to C6 on the left. Treatment requested is for Tramadol 50mg #90, Restoril 30mg #30, Protonix 20mg #60, and Anaprox 550mg #60. On 12/31/2014 Utilization Review non-certified the request for Tramadol 50mg #90 and cited was California Medical Treatment Utilization Schedule-Chronic Pain Treatment Guidelines, and ACOEM Guidelines. The request for Anaprox 550mg #60 was non-certified and cited was California Medical Treatment Utilization Schedule-Chronic Pain Treatment Guidelines, and Official Disability Guidelines. The request for Protonix 20mg, # 60 was non-certified and cited was California Medical Treatment Utilization Schedule-Chronic Pain Treatment Guidelines. The request for Restoril 30mg, # 30 was non-certified and cited was Official Disability Guidelines, and ACOEM Guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tramadol 50mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47-48, Chronic Pain Treatment Guidelines Page(s): 80-82. Decision based on Non-MTUS Citation ACOEM guidelines updated back chapter 2007 and third edition, pages 111-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for the treatment of chronic pain Page(s): 93-96.

Decision rationale: The review of the medical documentation indicates that the requested medication, Ultram 50 mg is not medically necessary and indicated for the treatment of the claimant's chronic pain condition. Per California MTUS, Ultram (Tramadol) is a synthetic opioid which affects the central nervous system and is indicated for the treatment of moderate to severe pain. The treatment of chronic pain with any opioid agent requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include current pain: last reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid, and the duration of pain relief. Per the medical documentation there has been no documentation of the medications pain relief effectiveness and no clear documentation that the patient has responded to ongoing opioid therapy. According to the California MTUS Guidelines there has to be certain criteria followed including an ongoing review and documentation of pain relief and functional status. This does not appear to have occurred with this patient. In addition, the documentation provided is lacking of California MTUS Opioid compliance guidelines including risk assessment profile, attempts at weaning/tapering, updated urine drug screen, updated efficacy, and an updated signed patient contract between the provider and the claimant. The patient may require a multidisciplinary evaluation to determine the best approach to treatment of his chronic pain syndrome. Medical necessity for the requested treatment has not been established. The requested treatment is not medically necessary.

Restoril 30mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 22, 67-68.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

Decision rationale: Temazepam (brand name Restoril) is an intermediate-acting 3-hydroxy hypnotic of the benzodiazepine class of psychoactive drugs. Temazepam is approved for the short-term treatment of insomnia. Long-term use is not recommended as there are associated risks of impaired function and memory with use more than opioids, as well as Temazepam may be habit forming. There is no documentation indicating the claimant has a diagnosis of insomnia

Medical necessity for the requested treatment has not been established. The requested treatment is not medically necessary.

Protonix 20mg #60: 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 PPIs
Page(s): 68.

Decision rationale: Per California MTUS 2009 proton pump inhibitors are recommended for patients taking NSAIDs with documented GI distress symptoms or specific GI risk factors. There is no documentation indicating the patient has any symptoms or GI risk factors. GI risk factors include: age >65, history of peptic ulcer, GI bleeding, or perforation; concurrent use of aspirin, corticosteroids, and/or anticoagulants or high dose/multiple NSAID. Based on the available information provided for review, the medical necessity for Protonix has not been established. The patient is not presently maintained on any NSAID medication. Medical necessity for the requested medication is not established. The requested medication is not medically necessary.

Anaprox 550mg #60: 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
Page(s): 67.

Decision rationale: The requested medication, Anaprox is not medically necessary for the treatment of the claimant's pain condition. Anaprox is a nonsteroidal anti-inflammatory medication (NSAID). These medications are recommended for the treatment of chronic pain as a second line therapy after acetaminophen. The documentation does not indicate the claimant has had significant functional improvement from the chronic use of this medication. Medical necessity for the requested medication has not been established. Medical necessity for the requested item has been established. The requested treatment is not medically necessary.