MAXIMUS Federal Services

Case Number:	CM15-0009960		
Date Assigned:	02/06/2015	Date of Injury:	06/15/1999
Decision Date:	04/21/2015	UR Denial Date:	12/11/2014
Priority:	Standard	Application Received:	01/16/2015

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: Physical Medicine & Rehabilitation

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 37-year-old female who reported an injury on 08/15/1999 due to an unspecified mechanism of injury. The injured worker reportedly sustained an injury to her low back. The injured worker's treatment history included medications and an ergonomic examination of the injured worker's work station. The injured worker was evaluated on 01/09/2014. The injured worker's medications included Voltaren 100 mg, cyclobenzaprine comfort pac, Ultram 50 mg, Norco 10/325 mg, and Prilosec 20 mg. Examination of the injured worker revealed focal tenderness and trigger points of the low back. The injured worker also had restricted range of motion secondary to pain with a negative straight leg raising test bilaterally. No treatment plan was provided for this injured worker. No Request for Authorization form was submitted to support the request.

IMR ISSUES, DECISIONS AND RATIONALES

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

Diclofenac ER 100mg #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic pain and NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 63.

Decision rationale: The requested diclofenac ER 100 mg is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does recommend nonsteroidal anti-inflammatory drugs in the management of chronic pain. However, the California Medical Treatment Utilization Schedule recommends that continued use of medications be supported by documented functional benefit and pain relief. The clinical documentation submitted for review does not provide any evidence of pain relief or increased function related to medication usage. Additionally, the request as it is submitted does not clearly identify a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested diclofenac ER 100 mg is not medically necessary or appropriate.

Cyclobenzaprine Comfort Pac #2 units: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63.

Decision rationale: The requested cyclobenzaprine comfort pac #2 units are not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends short term use of muscle relaxants for acute exacerbations of chronic pain. The clinical documentation submitted for review does indicate that the injured worker has trigger points and musculature tenderness that would benefit from the use of this type of medication. However, the request is for 2 units of a comfort pac. This is well in excess of the 2 to 3 week usage recommendation. There were no exceptional factors noted to support extending treatment beyond guideline recommendations. Furthermore, the request as it is submitted does not provide a frequency of use. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested cyclobenzaprine comfort pac #2 units are not medically necessary or appropriate.

Tramadol HCL 50mg #180: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-Going Management Page(s): 78.

Decision rationale: The requested tramadol HCl 50 mg #180 is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends the ongoing use of opioids in the management of chronic pain be supported by documented functional benefit, pain relief, managed side effects, and evidence that the injured worker is monitored for

aberrant behavior. The clinical documentation submitted for review does not provide any indication of pain relief, functional benefit, or that the injured worker is monitored for aberrant behavior. Therefore, ongoing use of this medication would not be supported. Additionally, the request as it is submitted does not clearly identify a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested tramadol HCl 50 mg #180 is not medically necessary or appropriate.

Omeprazole 20mg #120: 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 & cardiovascular risk Page(s): 68.

Decision rationale: The requested omeprazole 20 mg #120 is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends gastrointestinal protectants for injured workers who are at risk for developing gastrointestinal events related to medication usage. The clinical documentation submitted for review does not provide an adequate assessment of the injured worker's gastrointestinal system to support that they are at risk for developing gastrointestinal events related to medication usage. Therefore, the use of this medication is not supported. Additionally, the request as it is submitted does not clearly identify a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested omeprazole 20 mg #120 is not medically necessary or appropriate.

Hydrocodone/ACET 10-325mg #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 Opioids, On-Going Management Page(s): 78.

Decision rationale: The requested hydrocodone/acetaminophen 10/325 mg #60 is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends the ongoing use of opioids in the management of chronic pain be supported by documented functional benefit, pain relief, managed side effects, and evidence that the injured worker is monitored for aberrant behavior. The clinical documentation submitted for review does not provide any indication of pain relief, functional benefit, or that the injured worker is monitored for aberrant behavior. Therefore, ongoing use of this medication would not be supported. Additionally, the request as it is submitted does not clearly identify a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested hydrocodone/acetaminophen 10/325 mg #60 is not medically necessary or appropriate.