

Case Number:	CM15-0168837		
Date Assigned:	09/09/2015	Date of Injury:	04/08/2011
Decision Date:	10/26/2015	UR Denial Date:	08/05/2015
Priority:	Standard	Application Received:	08/27/2015

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, Pain Management

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 63 year old female, who sustained an industrial injury on 04-08-2011. She has reported injury to the low back. The diagnoses have included chronic low back pain; lumbar sprain-strain; lumbar degenerative disc disease; lumbar radiculopathy; lumbar stenosis; and lumbar spondylosis. Treatment to date has included medications, diagnostics, TENS (transcutaneous electrical nerve stimulation) unit, injections, chiropractic therapy, physical therapy, and home exercise program. Medications have included Tramadol, Gabapentin, Voltaren Gel, Trazodone, and Omeprazole. A progress note from the treating physician, dated 07-02-2015, documented a follow-up visit with the injured worker. The injured worker reported unchanged low back pain and stiffness; left leg pain and paresthesias; right leg pain and paresthesias; bilateral leg pain and weakness; difficulty with lifting, pushing, pulling, and bending; and difficulty with heavy lifting. It is noted in the documentation that physical therapy has helped improve her mobility; TENS unit provides her with a temporary relief. Objective findings included tenderness to palpation of the lumbar spine; motion is guarded due to pain; decreased lumbar ranges of motion; and the neuro-circulatory system is intact. The treatment plan has included the request for 60 tablets of Tramadol-Acetaminophen 37.5-325mg; 30 tablets of Trazodone 50mg; 1 tube of Voltaren Gel 1%; and 60 capsules of Omeprazole 20mg.

IMR ISSUES, DECISIONS AND RATIONALES

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

60 Tablets of Tramadol/APAP 37.5/325mg: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use, Opioids, dealing with misuse & addiction, Opioids, psychological intervention, Opioids for neuropathic pain, Opioids, dosing, Opioids, differentiation: dependence & addiction, Opioids, screening for risk of addiction (tests), Opioids, cancer pain vs. nonmalignant pain, Opioids (Classification), Opioids, indicators for addiction, Opioids for chronic pain, Opioids, pain treatment agreement, Opioids, steps to avoid misuse.

Decision rationale: Regarding the request for Tramadol/APAP 37.5/325mg, California Pain Medical Treatment Guidelines note that it is an opiate pain medication. Due to high abuse potential, close follow-up is recommended with documentation of analgesic effect, objective functional improvement, side effects, and discussion regarding any aberrant use. Guidelines go on to recommend discontinuing opioids if there is no documentation of improved function and pain. Within the documentation available for review, there is indication that the medication is improving the patient's function and pain with no intolerable side effects or aberrant use. In light of the above, the currently requested Tramadol/APAP 37.5/325mg is medically necessary.

30 Tablets of Trazodone 50mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Mental Illness & Stress, Trazodone (Desyrel).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain, Sleep Medication, Insomnia treatment.

Decision rationale: Regarding the request for Trazodone, California MTUS guidelines are silent regarding the use of sedative hypnotic agents. ODG recommends the short-term use (usually two to six weeks) of pharmacological agents only after careful evaluation of potential causes of sleep disturbance. They go on to state the failure of sleep disturbances to resolve in 7 to 10 days, may indicate a psychiatric or medical illness. It is recommended that treatments for insomnia should reduce time to sleep onset, improve sleep maintenance, avoid residual effects and increase next-day functioning. Within the documentation available for review, there are no subjective complaints of insomnia, no discussion regarding how frequently the insomnia complaints occur or how long they have been occurring, no statement indicating what behavioral treatments have been attempted for the condition of insomnia, and no statement indicating how the patient has responded to Trazodone treatment. In the absence of such documentation, the currently requested Trazodone is not medically necessary.

1 Tube of Voltaren Gel 1%: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: Regarding the request for Voltaren gel, guidelines state that topical NSAIDs are recommended for short-term use. Oral NSAIDs contain significantly more guideline support, provided there are no contraindications to the use of oral NSAIDs. Within the documentation available for review, there is no indication that the patient has obtained any specific analgesic effect (in terms of percent reduction in pain, or reduced NRS) or specific objective functional improvement from the use of Voltaren gel. Additionally, there is no documentation that the patient would be unable to tolerate oral NSAIDs, which would be preferred, or that the Voltaren is for short-term use, as recommended by guidelines. In the absence of clarity regarding those issues, the currently requested Voltaren gel is not medically necessary.

60 Capsules of Omeprazole 20mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Proton Pump Inhibitors (PPIs).

Decision rationale: Regarding the request for omeprazole (Prilosec), California MTUS states that proton pump inhibitors are appropriate for the treatment of dyspepsia secondary to NSAID therapy or for patients at risk for gastrointestinal events with NSAID use. Within the documentation available for review, there is no indication that the patient has complaints of dyspepsia secondary to NSAID use, a risk for gastrointestinal events with NSAID use, or another indication for this medication. Additionally, it appears the patient stopped this medicine due to intolerable diarrhea. In light of the above issues, the currently requested omeprazole (Prilosec) is not medically necessary.