MAXIMUS Federal Services

Case Number:	CM15-0027146		
Date Assigned:	02/19/2015	Date of Injury:	07/01/2003
Decision Date:	05/19/2015	UR Denial Date:	02/04/2015
Priority:	Standard	Application Received:	02/12/2015

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 63-year-old female who reported injury on 07/01/2003. The mechanism of injury was the injured worker fell from a chair while attempting to sit down. The diagnosis included lumbosacral sprain/strain, lumbosacral spondylosis, obesity, and lumbago. The treatment included medications, diagnostics, and a total right knee arthroplasty. There was no physician documentation from the requested date of service 02/24/2011. The diagnoses included lumbosacral spondylosis without myelopathy, obesity, and lumbago.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective request for Napro 550mg, QTY: 120, provided on date of service: 2/24/11: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 67-73.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 67.

Decision rationale: The California MTUS guidelines indicate that NSAIDS are recommended for short term symptomatic relief of mild to moderate pain. There should be documentation of objective functional improvement and an objective decrease in pain. There was no clinical documentation for the requested date of service. The rationale for the use of the medication was not provided. There was a lack of documentation of objective functional improvement and an objective decrease in pain. Additionally, the request as submitted failed to indicate the frequency. Given the above, the Retrospective request for Napro 550mg, QTY: 120, provided on date of service: 2/24/11 is not medically necessary.

Retrospective request for Tizanidine 2mg, QTY: 120, provided on date of service: 2/24/11: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 64-66.

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

Decision rationale: The California MTUS guidelines recommend muscle relaxants as a second line option for the short term treatment of acute low back pain, less than 3 weeks and there should be documentation of objective functional improvement. There was no clinical documentation submitted for review dated 02/24/2011. The duration of use could not be established. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Retrospective request for Tizanidine 2mg, QTY: 120, provided on date of service: 2/24/11 is not medically necessary.

Retrospective request for Tramadol 50mg, QTY: 120, provided on date of service: 2/24/11: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol (Ultram) Page(s): 93-94, 113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic pain, ongoing management Page(s): 60, 78.

Decision rationale: The California MTUS guidelines recommend opiates for chronic pain. There should be documentation of an objective improvement in function, an objective decrease in pain, and evidence that the injured worker is being monitored for aberrant drug behavior and side effects. The cumulative dosing of all opiates should not exceed 120 mg oral morphine equivalents per day. There was no clinical documentation submitted for review. As such, there was a lack of documentation of objective functional improvement, objective decrease in pain, and documentation the injured worker was being monitored for aberrant drug behavior and side effects on that date of service. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the Retrospective request for Tramadol 50mg, QTY: 120, provided on date of service: 2/24/11 is not medically necessary.

Retrospective request for Hydrocodone 325mg, QTY: 60, provided on date of service: 2/24/11: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for chronic pain Page(s): 80.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic pain, ongoing management, opioid dosing Page(s): 60, 78, 86.

Decision rationale: The California MTUS guidelines recommend opiates for chronic pain. There should be documentation of an objective improvement in function, an objective decrease in pain, and evidence that the injured worker is being monitored for aberrant drug behavior and side effects. The cumulative dosing of all opiates should not exceed 120 mg oral morphine equivalents per day. There was no clinical documentation submitted for review. As such, there was a lack of documentation of objective functional improvement, objective decrease in pain, and documentation the injured worker was being monitored for aberrant drug behavior and side effects on that date of service. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the Retrospective request for Hydrocodone 325mg, QTY: 60, provided on date of service: 2/24/11 is not medically necessary.

Retrospective request for Gabapentin 600mg, QTY: 60, provided on date of service: 2/24/11: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs) Page(s): 16-22.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepileptic Drugs Page(s): 16.

Decision rationale: The California MTUS guidelines recommend antiepilepsy medications as a first line medication for treatment of neuropathic pain. There should be documentation of an objective decrease in pain of at least 30 % - 50% and objective functional improvement. There was no clinical documentation submitted for review to support the request. There was a lack of documentation of at least 30% to 50% pain relief, and objective functional improvement. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Retrospective request for Gabapentin 600mg, QTY: 60, provided on date of service: 2/24/11 is not medically necessary.

Retrospective request for Omeprazole, QTY: 60, provided on date of service: 2/24/11: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 69.

Decision rationale: The California MTUS guidelines recommend proton pump inhibitors for injured workers at intermediate risk or higher for gastrointestinal events and are also for the treatment of dyspepsia secondary to NSAID therapy. There was no clinical documentation submitted for review. As such, there was a lack of documentation indicating the injured worker had been found to be at intermediate or higher risk for gastrointestinal events. Additionally, as the NSAID was found to be not medically necessary, this medication would not be medically necessary. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the Retrospective request for Omeprazole, QTY: 60, provided on date of service: 2/24/11 is not medically necessary.

Retrospective request for Trepa 300mg, QTY: 180, provided on date of service: 2/24/11: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain.

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

Decision rationale: The Official Disability Guidelines indicate that Trepadone is not recommended. The rationale for use was not provided. There was no physician documentation submitted for the requested date of service. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Retrospective request for Trepa 300mg, QTY: 180, provided on date of service: 2/24/11 is not medically necessary.