

Case Number:	CM15-0043379		
Date Assigned:	03/13/2015	Date of Injury:	10/20/2004
Decision Date:	05/22/2015	UR Denial Date:	02/09/2015
Priority:	Standard	Application Received:	03/06/2015

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: Pediatrics, 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 52 year old female, who sustained an industrial injury on 10/20/2004. The mechanism of injury was not noted. The injured worker was diagnosed as having cervical radiculopathy, thoracic and lumbar disc bulges, right shoulder tenosynovitis, status post right shoulder surgery in 7/2012, left shoulder strain, and bilateral wrist/hand strains. Treatment to date has included surgical (including cervical fusion in 2/2009) and conservative measures, including diagnostics, medications, physical therapy, shockwave therapy, and chiropractic. Currently, the injured worker complains of pain in the neck, upper and lower back, bilateral shoulders, and bilateral wrists/hands. Sensation to light touch was diminished in the left lateral shoulder, left dorsal thumb web, left small tip and left long tip. Medications included Tramadol, Omeprazole, Ambien, and Flexaril. Drug testing report, dated 1/16/2015, was inconsistent with prescribed medications. Medication refills were requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tramadol 80 mg #60 with 3 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use 4) On-Going Management Page(s): 78.

Decision rationale: The IW is documented to be on an opioid for pain relief. Documentation did not include review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. This request is not medically necessary and reasonable.

Flexeril 7.5 mg #60 with 3 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63-64.

Decision rationale: Recommended for a short course of therapy. Limited, mixed-evidence does not allow for a recommendation for chronic use. The greatest effect appears to be in the first 4 days of treatment. The documentation does reference muscle spasm that the Flexeril would be used for however at this time frame it is not indicated. This request is not medically necessary and appropriate.

Prilosec 20 mg 330 with 3 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68-69.

Decision rationale: According to MTUS guidelines it is necessary to determine if the patient is at risk for gastrointestinal events. Risk factors are: (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA). A history of ulcer complications is the most important predictor of future ulcer complications associated with NSAID use. There are no notations of risk factors for GI side effects in the progress notes. This request is not medically necessary and appropriate.

Ambien 10 mg #30 with 3 refills: 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), Treatment Index, 11th Edition (web), 2014, Pain and Zolpidem.

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

Decision rationale: Per ODG pharmacological agents for insomnia should only be used after careful evaluation of potential causes of sleep disturbance for the etiology. Ambien is indicated for the short-term treatment of insomnia with difficulty of sleep onset (7-10 days). Ambien CR is indicated for treatment of insomnia with difficulty of sleep onset and/or sleep maintenance. There is no discussion of an investigation into the origin of the sleep disturbance and non-pharmacological interventions that may have been utilized. Due to adverse effects, FDA now requires lower doses for zolpidem. The dose of zolpidem for women should be lowered from 10 mg to 5 mg for IR products. This request is not medically necessary and appropriate.