

Case Number:	CM15-0053191		
Date Assigned:	03/26/2015	Date of Injury:	08/20/2012
Decision Date:	05/01/2015	UR Denial Date:	03/06/2015
Priority:	Standard	Application Received:	03/20/2015

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: Texas, Illinois

Certification(s)/Specialty: Preventive Medicine, Occupational 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:

This 32-year-old female sustained an industrial injury to the back on 8/20/12. Previous treatment included magnetic resonance imaging, electromyography, physical therapy, home exercise, stretching, activity modification, heat/cold, medications, transcutaneous electrical nerve stimulator unit and lumbar orthotic. In the most recent relevant PR-2 submitted for review dated 11/16/14, the injured worker complained of low back pain 5/10 on the visual analog scale with left lower extremity symptoms. The injured worker reported current medication dosing regimen allowed her to complete activities of daily living. Tramadol facilitated elimination of immediate release opioids. Physical exam was remarkable for lumbar spine with positive straight leg raise and limited range of motion with diminished sensation in the right L4, L5 and S1 distributions. Current diagnoses included status post remote L4-5 decompression, protrusion L4-5 with no significant neural encroachment and lumbar spondylosis L4-S1. The treatment plan included requests for epidural steroid injection, a cane and physical therapy and medications (Tramadol, Naproxen, Protonix and Cyclobenzaprine).

IMR ISSUES, DECISIONS AND RATIONALES

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

Retro Tramadol 150mg #60 DOS: 1/22/15: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78-81.

Decision rationale: The injured worker sustained a work related injury on 8/20/12. The medical records provided indicate the diagnosis of status post remote L4-5 decompression, protrusion L4-5 with no significant neural encroachment and lumbar spondylosis L4-S1. Treatments have included physical therapy, home exercise, stretching, activity modification, heat/cold, medications, transcutaneous electrical nerve stimulator unit and lumbar orthotic. The medical records provided for review do not indicate a medical necessity for Retro Tramadol 150mg #60 DOS: 1/22/15. The MTUS recommend that individuals on opioid maintenance treatment be monitored for pain control, activities of daily living, adverse effects to the opioids, aberrant behavior; to discontinue opioids if there is no documented evidence of overall improvement or if there is evidence of drug abuse or illegal activity. The MTUS recommends the use of the lowest dose of opioids for the short term treatment of moderate to severe pain. The MTUS does not recommend the use of opioids for more than 70 days in the treatment of chronic pain due to lack of research supporting benefit beyond 70 days, and increasing adverse effects. The records indicate the injured worker has been taking this medication at least since 11/2014, the pain appears has not improved in the visual analogue scale, there has been no overall improvement in function, therefore the requested treatment is not medically necessary.

Retro Pantoprazole 20mg #90 DOS: 1/22/15: 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. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) ODG Workers' Compensation Drug Formulary PPI (Proton pump inhibitor).

Decision rationale: The injured worker sustained a work related injury on 8/20/12. The medical records provided indicate the diagnosis of status post remote L4-5 decompression, protrusion L4-5 with no significant neural encroachment and lumbar spondylosis L4-S1. Treatments have included physical therapy, home exercise, stretching, activity modification, heat/cold, medications, transcutaneous electrical nerve stimulator unit and lumbar orthotic. The medical records provided for review do not indicate a medical necessity for Retro Pantoprazole 20mg #90 DOS: 1/22/15. The MTUS recommends the use of proton pump inhibitor by individuals at risk of gastrointestinal events who are being treated with NSAIDs. The report indicates the injured worker has a history of gastrointestinal upset to the use of NSAIDs, but prior treatment with omeprazole, a first line proton pump inhibitor, was not beneficial. The requested treatment is a second line proton pump inhibitor in the Official Disability Guidelines "N" list that require Utilization review. It is not medically necessary because there is no indication the injured worker

has failed treatment with other first line proton pump inhibitors besides omeprazole, therefore the requested treatment is not medically necessary.

Retro Cyclobenzaprine 7.5mg #90 DOS: 1/22/15: 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: The injured worker sustained a work related injury on 8/20/12. The medical records provided indicate the diagnosis of status post remote L4-5 decompression, protrusion L4-5 with no significant neural encroachment and lumbar spondylosis L4-S1. Treatments have included physical therapy, home exercise, stretching, activity modification, heat/cold, medications, transcutaneous electrical nerve stimulator unit and lumbar orthotic. The medical records provided for review do not indicate a medical necessity for Retro Cyclobenzaprine 7.5mg #90 DOS: 1/22/15. The MTUS recommends the optional use caution of the non-sedating muscle relaxants for the short-term treatment of acute exacerbation of low back pain. The records indicate the injured worker has used this medication for some time. The MTUS does not recommend the use of Cyclobenzaprine for more than 2-3 days. The dose is 5-10mg orally three times daily, and therefore the requested treatment is not medically necessary.