

<b>Case Number:</b>	CM15-0054054		
<b>Date Assigned:</b>	03/27/2015	<b>Date of Injury:</b>	01/07/2003
<b>Decision Date:</b>	05/14/2015	<b>UR Denial Date:</b>	02/20/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/23/2015

### 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, Arizona

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 71-year-old female who reported injury on 01/07/2003. The mechanism of injury was the injured worker tripped and twisted her ankle. The injured worker was status post left total knee replacement in 2009. The documentation of 02/02/2015 revealed the injured worker had a positive Apley's grind test bilaterally. There was crepitus on the right knee. There were increased spasms. The treatment plan included a total knee replacement. The injured worker was diagnosed with radiculopathy of the upper extremity, lumbosacral spondylosis, and lumbar disc displacement. The treatment plan included pain management follow-up, psychiatric follow-up, Tylenol #4 300/60 mg and omeprazole 20 mg.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Pain management follow-up:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints, Chapter 13 Knee Complaints, Chapter 15 Stress Related Conditions.

**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, Office Visit.

**Decision rationale:** The Official Disability Guidelines indicate that the need for a clinical office visit with a health care provider is individualized based upon a review of the injured workers concerns, signs and symptoms, clinical stability and reasonable physician judgment and medications the injured worker is taking. The clinical documentation submitted for review failed to provide a rationale for the pain management follow-up. The injured worker was utilizing medications that could be managed by the primary care physician. Given the above and the lack of documentation, the request for pain management follow-up is not medically necessary.

**Psych follow-up:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints, Chapter 13 Knee Complaints, Chapter 15 Stress Related Conditions.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness & Stress Chapter, Office Visits.

**Decision rationale:** The Official Disability Guidelines indicate that the need for a clinical office visit with a health care provider is individualized based upon a review of the injured workers concerns, signs and symptoms, clinical stability and reasonable physician judgment and medications the injured worker is taking. The clinical documentation submitted for review failed to provide a rationale for the pain psych follow-up. Given the above and the lack of documentation, the request for pain psych follow-up is not medically necessary.

**Omeprazole 20mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines non-steroidal anti-inflammatory drugs (NSAIDs) Page(s): 68-69.

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

**Decision rationale:** The California Medical Treatment Utilization Schedule Guidelines recommend proton pump inhibitors for injured workers at intermediate risk or higher for gastrointestinal events. Additionally, the medication is utilized to treatment dyspepsia secondary to NSAID therapy. The clinical documentation submitted for review failed to provide the legible documentation the injured worker had dyspepsia. There was a lack of documentation regarding the efficacy of the requested medication. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for omeprazole 20 mg #60 is not medically necessary.

**Tylenol #4- 300/60mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 76-80, 92, 124.

**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 Medical Treatment Utilization Schedule 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 clinical documentation submitted for review failed to provide documentation the injured worker was being monitored for aberrant drug behavior and side effects. There was a lack of documentation of objective functional improvement and objective decrease in pain. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Tylenol #4- 300/60mg #60 is not medically necessary.