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| Case Number: | CM14-0089660 | | |
| Date Assigned: | 09/19/2014 | Date of Injury: | 12/06/2002 |
| Decision Date: | 10/24/2014 | UR Denial Date: | 06/02/2014 |
| Priority: | Standard | Application Received: | 06/13/2014 |

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in Illinois. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 61-year-old female who reported an injury on 12/06/2002 due to an unspecified mechanism of injury. The injured worker reportedly sustained an injury to her neck and upper extremity. The injured worker's treatment history included physical therapy, injections, multiple medications and a home exercise program. The injured worker was evaluated on 05/05/2014. It was documented that the injured worker was being seen due to an acute exacerbation of her chronic low back pain. The injured worker was provided a Toradol injection to assist with her acute pain. The injured worker's medications included Motrin 800 mg, Ultram 50 mg, Flexeril 10 mg, Voltaren 100 mg, Norco 10/325 mg and Ambien 10 mg. The injured worker was advised to continue her home exercise program. A Request for Authorization to support the injured worker's treatment plan was submitted on 05/02/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ultram 50mg, #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-Going Management.

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

Decision rationale: The California Medical Treatment Utilization Schedule recommends ongoing documentation of a quantitative assessment of pain relief, managed side effects, functional increases, and evidence that the injured worker is monitored for aberrant behavior to support ongoing opioid usage. The clinical documentation does indicate that the injured worker has been taking this medication since at least 01/2014. However, the injured worker's most recent clinical assessment dated 05/02/2014 does not provide any assessment of the injured worker's pain or relief resulting from the use of medication. There is no documentation of functional benefit. There is no indication that the injured worker is monitored for aberrant behavior. Therefore, ongoing use of this medication would not be supported in this clinical situation. Furthermore, the request as it is submitted does not clearly identify frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Ultram 50 mg #90 is not medically necessary or appropriate.

Flexeril 10mg, #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants, Antispasmodics.

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

Decision rationale: The California Medical Treatment Utilization Schedule recommends short durations of treatment of Flexeril not to exceed 2 to 3 weeks for acute exacerbations of chronic pain. Although it is noted in the documentation that the injured worker is having an acute exacerbation of chronic pain, the clinical documentation indicates that the injured worker has been taking this medication since at least 01/2014. As California Medical Treatment Utilization Schedule does not support the use of this medication in chronic pain management, continued use would not be supported. Furthermore, the request as it is submitted does not clearly identify a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Flexeril 10mg, #90 is not medically necessary or appropriate.

Voltaren Gel 100mg, #1: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

Decision rationale: The California Medical Treatment Utilization Schedule does not recommend the long term use of topical non-steroidal anti-inflammatory drugs. The clinical documentation submitted for review does indicate that the injured worker has been on the medication since at least 01/2014. Therefore, continued use of this medication would not be supported. Additionally, the clinical documentation submitted for review indicates that the injured worker's main pain generator is the back. California Medical Treatment Utilization

Schedule does not recommend the use of topical non-steroidal anti-inflammatory drugs for spine pain. The request as it is submitted does not clearly identify a frequency of treatment or applicable body part. In the absence of this information the appropriateness of the request itself cannot be determined. As such, the requested Voltaren Gel 100mg, #1 is not medically necessary or appropriate.

Ambien 10mg, #30: Upheld

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

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, Insomnia Treatments

Decision rationale: The California Medical Treatment Utilization Schedule does not address this medication. Official Disability Guidelines recommend the short term use of Ambien to assist with insomnia related to chronic pain. The clinical documentation submitted for review does indicate that the injured worker has been on this medication since at least 2013. Therefore, ongoing use of this medication would not be supported. Additionally, the injured worker's most recent clinical evaluation does not provide any assessment of the injured worker's sleep patterns to support ongoing insomnia related to chronic pain that requires pharmacological intervention. Furthermore, the request as it is submitted does not clearly identify a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Ambien 10mg, #30 is not medically necessary or appropriate.

Retrospective Request of Intramuscular Injection of Toradol 2cc: Upheld

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

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, Toradol Injections

Decision rationale: The California Medical Treatment Utilization Schedule does not specifically address Toradol injections. Official Disability Guidelines recommend Toradol injections for acute exacerbations of pain to reduce opioid medication intake. The clinical documentation does indicate that the injured worker is having an acute exacerbation of pain. However an adequate assessment of that pain to determine the need for a Toradol injection was not provided. There was no documentation of significantly limited functionality that would require injection therapy. As such, the requested Retrospective Request of Intramuscular Injection of Toradol 2cc is not medically necessary or appropriate.