MAXIMUS Federal Services

Case Number:	CM15-0077241		
Date Assigned:	04/28/2015	Date of Injury:	03/13/2014
Decision Date:	07/03/2015	UR Denial Date:	04/10/2015
Priority:	Standard	Application Received:	04/22/2015

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, Pain Management

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 29 year old male, who sustained an industrial injury on 03/13/2014. He reported injury to his neck, low back and left knee. Diagnoses included status post closed head injury without loss of consciousness, traumatic brain injury, post traumatic labyrinthine concussion, recurring syncopal episodes, cervical sprain/strain, cervical disc herniation, cervical paraspinal muscle spasm, cervical radiculitis/radiculopathy of the upper extremities and sacroiliitis of the bilateral sacroiliac joints. Treatment to date has included computed tomography scan of the abdomen, emergency surgery to the stomach, physical therapy, chiropractic care, acupuncture, medications, trigger point injections and x-rays. Urine toxicology testing dated 12/19/2014, 01/27/2015 and 02/24/2015 was submitted for review and was noted as inconsistent with prescribed therapy. According to a progress report dated 03/16/2015, the injured worker report pain over the bilateral buttock regions radiating to the posterior and lateral aspects of the bilateral thighs with numbness and tingling progressively increasing in severity. He also complained of progressive limited range of motion to the neck associated with severe muscle spasms. Pain was rated 8 on a scale of 1-10 with flare-ups reaching a 9. He experienced severe headaches with blurred vision and loss of consciousness. The level of pain while attempting to perform normal daily activities had progressively increased in the last couple of weeks. The provider recommended sacroiliac joint injections, and bilateral occipital nerve blocks. Currently under review is the request for Norco, Trazodone, Ultram, Prilosec and Solar Care FIR heating system with FIR heat pad.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325mg #60 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 91, 78-80, 124.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 44, 47, 75-79, 120 of 127.

Decision rationale: Regarding the request for Norco (hydrocodone/acetaminophen), California Pain Medical Treatment Guidelines state that this is an opiate pain medication. Due to high abuse potential, close follow-up is recommended with documentation of analgesic effect, objective functional improvement, side effects, and discussion regarding any aberrant use. Guidelines go on to recommend discontinuing opioids if there is no documentation of improved function and pain. Within the documentation available for review, there is no indication that the medication is improving the patient's function or pain (in terms of specific examples of functional improvement and percent reduction in pain or reduced NRS) and no discussion regarding aberrant use. As such, there is no clear indication for ongoing use of the medication. Opioids should not be abruptly discontinued, but unfortunately, there is no provision to modify the current request to allow tapering. In light of the above issues, the currently requested Norco (hydrocodone/acetaminophen) is not medically necessary.

Trazodone 1/2 #30 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 13-14. Decision based on Non-MTUS Citation Official Disability Guidelines - Pain - anti-depressants.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) Chronic Pain, Sleep Medication, Insomnia treatment.

Decision rationale: Regarding the request for trazodone, it appears that it is being utilized as a sleep aid. California MTUS guidelines are silent regarding the issue. ODG recommends the short-term use (usually two to six weeks) of pharmacological agents only after careful evaluation of potential causes of sleep disturbance. They go on to state the failure of sleep disturbances to resolve in 7 to 10 days, may indicate a psychiatric or medical illness. Within the documentation available for review, there is no current description of the patient's insomnia, no discussion regarding what behavioral treatments have been attempted, and no statement indicating how the patient has responded to treatment. Furthermore, there is no indication that the medication is being used for short-term use as recommended by guidelines. In the absence of such documentation, the currently requested trazodone is not medically necessary.

Ultram 50#30 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 93-94, 78-80, 124.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 44, 47, 75-79, 120 of 127.

Decision rationale: Regarding the request for Ultram, California Pain Medical Treatment Guidelines state that this is an opiate pain medication. Due to high abuse potential, close follow-up is recommended with documentation of analgesic effect, objective functional improvement, side effects, and discussion regarding any aberrant use. Guidelines go on to recommend discontinuing opioids if there is no documentation of improved function and pain. Within the documentation available for review, there is no indication that the medication is improving the patient's function or pain (in terms of specific examples of functional improvement and percent reduction in pain or reduced NRS) and no discussion regarding aberrant use. As such, there is no clear indication for ongoing use of the medication. Opioids should not be abruptly discontinued, but unfortunately, there is no provision to modify the current request to allow tapering. In light of the above issues, the currently requested Ultram is not medically necessary.

Prilosec 20 #30 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines proton pump inhibitors Page(s): 68-69.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 68-69 of 127.

Decision rationale: Regarding the request for omeprazole (Prilosec), California MTUS states that proton pump inhibitors are appropriate for the treatment of dyspepsia secondary to NSAID therapy or for patients at risk for gastrointestinal events with NSAID use. Within the documentation available for review, there is no indication that the patient has complaints of dyspepsia secondary to NSAID use, a risk for gastrointestinal events with NSAID use, or another indication for this medication. In light of the above issues, the currently requested omeprazole (Prilosec) is not medically necessary.

SolarCare FIR Heating system with FIR heat pad, portable (purchase): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines-Low Back.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation x Official Disability Guidelines (ODG), Low Back Chapter, Infrared therapy (IR).

Decision rationale: Regarding the request for SolarCare, CA MTUS does not specifically address the issue. ODG cites that infrared therapy is not recommended over other heat therapies.

Where deep heating is desirable, providers may consider a limited trial of IR therapy for treatment of acute LBP, but only if used as an adjunct to a program of evidence-based conservative care (exercise). Within the documentation available for review, the patient's pain is not acute and there is no indication that the device would be used as a trial and as adjunctive treatment to exercise. In light of the above issues, the currently requested SolarCare is not medically necessary.