

Case Number:	CM13-0008865		
Date Assigned:	03/07/2014	Date of Injury:	11/06/2010
Decision Date:	04/03/2014	UR Denial Date:	08/02/2013
Priority:	Standard	Application Received:	08/08/2013

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 Pain Management, has a subspecialty in Interventional Spine and is licensed to practice in California. 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:

This is a 52 year-old male who was injured on 11/06/2010. There were no medical reports from 2013 provided for this review. According to the 09/06/2012 report from [REDACTED], the diagnoses are: right knee chondromalacia patella; right knee degenerative joint disease; status post right knee arthroscopy and spinal issues deferred to [REDACTED]. The 09/06/2012 chiropractic report states that there is 6/10 low back pain. The 11/05/2012 chiropractic note from [REDACTED] lists the diagnoses as grade 1 spondylolithesis, herniated nucleus pulposus (HNP) of lumbar spine with radiculopathy and facet arthropathy. Pain was still 6/10. There was no information provided regarding this patient's medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

TRAMADOL 50MG #60 WITH 1 REFILL: 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): 93-94, 113.

Decision rationale: There is not enough information provided to confirm that the Tramadol is provided in accordance with MTUS guidelines. The requesting physician's report is not provided for review. There is no rationale provided for the medication. There are no current reports that show the patient has indications for use of tramadol. There is no current pain assessment available, and no current description of the patient's presentation. The patient has had chiropractic care and an orthovisc injection. There are no reports available that discuss if any first-line medication has been tried, prior to tramadol. Based on the limited information provided, the requested Tramadol is not medically necessary at this time.

PRILOSEC 20MG #120 WITH 1 REFILL: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68-69.

Decision rationale: There is not enough information provided to confirm that the Prilosec is provided in accordance with MTUS guidelines. The requesting physician's report is not provided for review. There is no rationale provided for the medication. There are no current reports that show the patient has indications for use of Prilosec, no discussion on any of the MTUS risk factors for gastrointestinal events. No mention of gastroesophageal reflux disease (GERD), and no mention of the use of nonsteroidal anti-inflammatory drugs (NSAIDs). Based on the limited information provided, the requested Prilosec is not medically necessary at this time.

DENDRACIN CREAM WITH 1 REFILL: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

Decision rationale: There is not enough information provided to confirm that the Dendracin Cream is provided in accordance with MTUS guidelines. The requesting physician's report is not provided for review. There is no rationale provided for the medication. Dendracin is methyl salicylate, benzocaine and menthol and Dendracin Neurodendraxin is capsaicin, menthol and methyl salicylate. The MTUS guidelines state that topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There are no reports available for review that discuss trials and failures of antidepressants and anticonvulsants. Based on the limited information provided, the requested Dendracin Cream is not medically necessary or appropriate.