

Case Number:	CM13-0017816		
Date Assigned:	10/11/2013	Date of Injury:	06/20/2002
Decision Date:	01/06/2014	UR Denial Date:	07/09/2013
Priority:	Standard	Application Received:	08/28/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Family Practice, and is licensed to practice in Texas. 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 physician 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.

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 patient is a 54-year-old male who reported injury on 06/20/2002 with the mechanism of injury being the patient was hit by a forklift. The patient had sensation that was altered over the right top of the left foot as compared to the right. The patient's diagnoses were stated to include cervical strain with right-sided radiculopathy, stomach upset and abdominal bloating secondary to pain medication use improved. The plan was stated to be an MRI of the cervical spine, tramadol 50 mg 1 tablet twice a day as needed for pain, Flexeril 10 mg 1 tablet twice a day for muscle spasms, Prilosec 1 to 2 tablets daily for stomach upset and bloating due to pain medication use, Ambien for 1 month for sleeping difficulty due to chronic pain as this has been helpful, and ibuprofen as needed for pain and inflammation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ibuprofen 800mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS and Ibuprofen Page(s): 67.

Decision rationale: The clinical documentation submitted for review indicated the patient had 13 sessions of physical therapy and the pain had decreased to 5/10 with activity. It was noted on the neurological examination that the patient had a moderate limp due to right leg and knee pain.

There was noted to be minimal tenderness of the right ankle and foot. The patient was noted to have a positive straight leg raise on the left at 60 degrees on the right and on the left at 80 degrees and seating position would cause low back pain and posterior thigh pain. MTUS Chronic Pain Guidelines recommend ibuprofen for inflammation and pain; however, clinical documentation submitted for review failed to provide the efficacy of the requested medication. The request for Ibuprofen 800 mg #60 is not medically necessary and appropriate.

Prilosec 20mg #60: Upheld

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

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

Decision rationale: MTUS Chronic Pain Guidelines recommend treatment of dyspepsia secondary to NSAID therapy with a proton pump inhibitor. The clinical documentation submitted for review indicated the patient experienced a stomach upset and bloating due to pain medication use and it indicated that the patient experienced efficacy of the medication; however, as the request for Ibuprofen was not approved, the request for Prilosec to treat the effects of the NSAID therapy would not be medically necessary. Since the primary procedure is not medically necessary, none of the associated services are medically necessary

MRI Cervical Spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck & Upper Back MRI section, Online Version..

Decision rationale: California MTUS/ACOEM Guidelines do not address repeat MRIs. Official Disability Guidelines recommend a repeat MRI if there is a significant change in symptoms or findings suggestive of a significant pathology. The clinical documentation dated 06/07/2012 revealed the patient had a cervical examination that showed slight to moderate spasm, more on the right than the left. The patient was noted to have a sensory alteration over the top of the left foot compared to the right, and was noted to have 2/4 motor strength which is noted to be normal. The patient's examination on 06/19/2013 was the same and failed to show a significant change in symptoms or findings suggestive of a significant pathology as the examination for the 1 year time frame was virtually unchanged in regards to the cervical spine. The request for a MRI Cervical Spine is not medically necessary and appropriate.

Tramadol 50mg #48: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol & on-going management of Opioids Page(s): 82, 78.

Decision rationale: MTUS Chronic Pain Guidelines do not recommend Tramadol as a first line therapy except in the treatment of neuropathic cancer pain or prompt pain relief when titrating a first line drug. Additionally, it is recommended that for ongoing treatment with opioids, the patient should have documentation of pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant or non-adherent drug related behaviors. Clinical documentation indicated that the medication was to be used for pain control. The clinical documentation submitted for review failed to provide documentation of the patient's analgesia and an improvement in ability to perform activities of daily living. The request for Tramadol 50mg #48 is not medically necessary and appropriate.

Flexeril 10mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine and Flexeril Page(s): 41.

Decision rationale: MTUS Chronic Pain Guidelines recommend Flexeril as a short course of therapy for spasms. The patient was noted to have a moderate spasm on the right cervical spine. The clinical documentation submitted for review indicated that the patient was using the medication as of the examination note dated 06/06/2012. It failed to provide the efficacy of the requested medication and failed to provide the necessity for exceeding guidelines recommendations with exceptional factors to support ongoing treatment. This medication is to be used for a short course of therapy per California MTUS guidelines. The request for Flexeril 10mg #60 is not medically necessary and appropriate.

Ambien 10mg #30: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain chapter on Zolpidem and Ambien from the Online Version..

Decision rationale: California MTUS/ACOEM Guidelines do not address Ambien. The Official Disability Guidelines indicate that Ambien is a short acting non-benzodiazepine recommended for short-term use, usually 2 to 6 weeks for treatment of insomnia. The clinical documentation submitted for review indicated the patient was using the medication on 06/06/2012 and that it had been helpful. The clinical documentation of 06/19/2013 indicated that the patient was using the medication for difficulty sleeping due to chronic pain, however, it

lacked exceptional factors to warrant non-adherence to guideline recommendations. Additionally, the submitted documentation failed to indicate if the patient had tried non-pharmacologic methods for sleep. The request for Ambien 10mg #30 is not medically necessary and appropriate.