

Case Number:	CM13-0019235		
Date Assigned:	10/11/2013	Date of Injury:	08/26/2011
Decision Date:	01/16/2014	UR Denial Date:	08/15/2013
Priority:	Standard	Application Received:	09/03/2013

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 physical medicine and rehabilitation, has a subspecialty in interventional spinal medicine, 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 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 has a date of injury on 8/26/11. The progress report dated 3/23/13 by [REDACTED] noted that the patient complained of constant low back pain with radiation to left lower extremity, persistent neck pain with radiation to bilateral upper extremities. The patient also complained of sleeplessness. Pain was rated at 3-4/10 without medication coming down to 2-3/10 with medication. The patient's diagnoses include: lumbar sprain/strain; thoracic sprain/strain; hand, multiple fracture, closed. Acetadryl 500-25 mg was prescribed for 1 pill at night for sleeplessness. The utilization review letter dated 8/16/13 made reference to a request dated 8/10/13 for the following medications: Mentoderm 3 gm; Topiramate 100mg; Tramadol 60mg #90; Acetadryl #50; Omeprazole 20mg #60. It was noted that the patient presented for a follow up for neck pain rated at 6/10. No progress report dated 8/10/13 or near that date was provided for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Mentoderm 3gm: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs).

Decision rationale: The Chronic Pain Medical Treatment Guidelines states that topical NSAIDs (non-steroidal anti-inflammatory drugs) are indicated for peripheral joint arthritis and tendinitis condition. Mentherm is a methyl salicylate/menthol combination cream, an NSAID. This patient presents with neck and back pains with radicular pains. The patient does not have a diagnosis for which a topical NSAID is indicated according to the Chronic Pain Medical Treatment Guidelines. The request for one prescription of Mentherm, 3 gm, is not medically necessary or appropriate.

Topamax 100mg (unknown quantity): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy Drugs Section Page(s): 16-17.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines anti-epilepsy drugs (AEDs).

Decision rationale: The Chronic Pain Medical Treatment Guidelines regarding recommends the use of anti-epilepsy drugs (AEDs) for neuropathic pain. The patient has pain down the legs from the L-spine, but the treater's diagnoses are primarily strain/sprain with hx of fractures. There is no documentation of neuropathic pain or a clear radiculopathy to warrant a neuropathic agent such as Topamax. The request for one prescription of Topiramate, 100 mg, is not medically necessary or appropriate.

Tramadol 60mg # 90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for Neuropathic Pain Page(s): 82,84.

Decision rationale: The Physician Reviewer's decision rationale: The Chronic Pain Medical Treatment Guidelines states that Tramadol is not recommended as a first-line therapy. Opioid analgesics and Tramadol have been suggested as a second-line treatment (alone or in combination with first-line drugs). It is unclear, by the medical records provided, what medications the patient has tried and failed. The Chronic Pain Medical Treatment Guidelines recommends a record of pain and function with the medication should be recorded. It is unclear in this case what functional benefit the patient has received with the use of this medication. Recommendation is for denial. The request for one prescription of Tramadol, 60 mg, 90 count, is not medically necessary or appropriate.

Omeprazole 20mg # 60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines GI (Gastrointestinal) Symptoms and Cardiovascular Risk Section Page(s): 69.

Decision rationale: The Physician Reviewer's decision rationale: The Chronic Pain Medical Treatment Guidelines supports the use of Omeprazole for patients who are at risk for gastrointestinal events such as: (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA (acetylsalicylic acid), corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA). The records do not appear to indicate that the patient has been experiencing any GI symptoms related to medication use. The treater does not provide any information regarding the patient's history of peptic ulcer, GI bleeding, concurrent use of ASA, corticosteroids, etc. The patient's GI risk is not assessed. The request for Omeprazole, 20 mg, 60 count, is not medically necessary or appropriate.