

Case Number:	CM13-0019771		
Date Assigned:	06/06/2014	Date of Injury:	02/10/2013
Decision Date:	07/31/2014	UR Denial Date:	08/28/2013
Priority:	Standard	Application Received:	09/03/2013

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 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:

The injured worker is a 48-year-old male who reported an injury on 02/10/2013. The mechanism of injury was not stated. Current diagnoses include lumbar strain and rule out radiculopathy. The injured worker was evaluated on 08/06/2013. The injured worker was actively participating in physical therapy with an improvement of symptoms. Physical examination revealed tenderness to palpation, spasm, reduced range of motion, positive straight leg raise, and reduced sensation in the left lower extremity. Treatment recommendations included a refill of the current medication regimen and completion of physical therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

RETROSPECTIVE 120 MEDROX OINTMENT 120G DOS:08/06/2013: 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: The MTUS Chronic Pain Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and

anticonvulsants have failed. There is no indication of a failure to respond to first-line oral medication prior to the initiation of a topical analgesic. There is also no frequency listed in the current request. As such, the request is not medically necessary and appropriate.

RETROSPECTIVE 60 HYDROCODONE 5/325MG #60 DOS:08/06/2013: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

Decision rationale: The MTUS Chronic Pain Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. There is no documentation of a failure to respond to non-opioid analgesics. There is also no documentation of a written consent or pain agreement. There is also no frequency listed in the current request. As such, the request is not medically necessary and appropriate.

RETROSPECTIVE 30 KETOPROFEN 75MG #30 DOS:08/06/2013: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67-72.

Decision rationale: The MTUS Chronic Pain Guidelines states NSAIDs are recommended for osteoarthritis at the lowest dose for the shortest period in patients with moderate to severe pain. For acute exacerbations of chronic pain, NSAIDs are recommended as a second-line option after acetaminophen. There was no indication that this injured worker was suffering from an acute exacerbation of chronic pain. There is also no frequency listed in the current request. As such, the request is not medically necessary and appropriate.

RETROSPECTIVE 30 OMEPRAZOLE DR 20MG #30 DOS:08/06/2013: 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: The MTUS Chronic Pain Guidelines state proton pump inhibitors are recommended for patients at intermediate or high risk for gastrointestinal events. Patients with no risk factor and no cardiovascular disease do not require the use of a proton pump inhibitor,

even in addition to a non-selective NSAID. There is no documentation of cardiovascular disease or increased risk factors for gastrointestinal events. There is also no frequency listed in the current request. As such, the request is not medically necessary and appropriate.

RETROSPECTIVE 60 ORPHENADRINE ER 100MG #60 DOS:08/06/2013: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63-66.

Decision rationale: The MTUS Chronic Pain Guidelines states muscle relaxants are recommended as a non-sedating second-line options for short-term treatment of acute exacerbations. The injured worker does demonstrate palpable muscle spasm. However, the MTUS Chronic Pain Guidelines do not recommend long-term use of muscle relaxants. There is no frequency listed in the current request. As such, the request is not medically necessary and appropriate.