

Case Number:	CM13-0023859		
Date Assigned:	11/15/2013	Date of Injury:	02/25/2013
Decision Date:	04/14/2014	UR Denial Date:	08/21/2013
Priority:	Standard	Application Received:	09/12/2013

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 & Rehabilitation, has a subspecialty in Pediatric Rehabilitation Medicine, 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. 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 patient is a 66-year-old female who reported an injury on 02/25/2013. The mechanism of injury was not provided for review. The documentation submitted for review included a chart note from 08/2012 and 07/2012. The 08/2012 chart note documented that the patient had slight to moderate improvement of low back pain and neck pain with chiropractic care. Physical findings included restricted range of motion of the cervical and lumbar spines, decreased grip strength on the right when compared to the left and tenderness to palpation over the cervical paraspinal musculature. It was noted that the patient was taking medications, to include Neurontin 600 mg, Zanaflex 4 mg, Voltaren 100 mg and omeprazole 20 mg. The patient's diagnoses at that time included a lumbar strain, thoracic sprain, cervical sprain and a lumbosacral sprain. The patient's treatment plan at that time was to continue chiropractic care with physiotherapy and work conditioning and to continue medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

ZANAFLEX 4MG: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Section Tizanidine (Zan).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Section Muscle Relaxants Page(s): 63..

Decision rationale: The requested Zanaflex 4 mg is not medically necessary or appropriate. The clinical documentation submitted for review did not provide a recent assessment of pain deficits that would benefit from medication management. The Medical Treatment Utilization Schedule does recommend the use of muscle relaxants for moderate to severe chronic pain and muscle spasms. However, as there was no recent documentation to support the need for this medication, the appropriateness of this medication cannot be determined. As such, the requested Zanaflex 4 mg is not medically necessary or appropriate.

VOLTAREN 100MG: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Section NSAIDs: Diclofe.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Section Topical Analgesics Page(s): 111..

Decision rationale: The requested Voltaren 100 mg is not medically necessary or appropriate. The Medical Treatment Utilization Schedule recommends the use of topical nonsteroidal anti-inflammatory drugs for short durations of treatment when oral formulations are not tolerated or are contraindicated for the patient. There was no recent clinical documentation to determine the appropriateness of this medication. As such, the requested Voltaren 100 mg is not medically necessary or appropriate

OMEPRAZOLE 20MG TWICE A DAY: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Section NSAIDs, GI symp.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Section NSAIDs, GI symptoms & cardiovascular risk, Pa.

Decision rationale: The requested omeprazole 20 mg twice a day is not medically necessary or appropriate. The Medical Treatment Utilization Schedule recommends the use of gastrointestinal protectives for patients who are at risk for developing gastrointestinal events related to medication usage. There was no recent clinical documentation submitted for review to determine the appropriateness of this medication. As such, the requested omeprazole 20 mg twice a day is not medically necessary or appropriate

NEURONTIN 600MG: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Section Gabapentin Page.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Section Anti-epilepsy drugs (AEDs) Page(s): 16..

Decision rationale: The requested Neurontin 600 mg is not medically necessary or appropriate. The Medical Treatment Utilization Schedule does recommend the use of anticonvulsants as a first-line treatment in the management of chronic pain. However, the clinical documentation did not include a recent assessment for evaluation of the employee to determine the appropriateness of this medication. As such, the requested Neurontin 600 mg is not medically necessary or appropriate. Disclaimer: MAXIMUS