MAXIMUS Federal Services

Case Number:	CM13-0027657		
Date Assigned:	01/10/2014	Date of Injury:	02/21/1997
Decision Date:	07/30/2014	UR Denial Date:	08/19/2013
Priority:	Standard	Application Received:	09/23/2013

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 & Rehabilitation and is licensed to practice in Nevada. 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 61-year-old individual who was reportedly injured on February 21, 1997. The mechanism of injury was not listed in these records reviewed. The most recent progress note dated December 13, 2013, indicated that there were ongoing complaints of neck pain, bilateral shoulder and bilateral thumb pains as well as bilateral lower extremity pain. The physical examination demonstrated the injured employee to be in moderate distress with tenderness to palpation of the lower cervical spine, a decrease in range of motion of the lumbar spine, and pain with flexion extension of the lumbar spine. Diagnostic imaging studies were not presented for review. Previous treatment included multiple pain interventions, noted not to be particularly efficacious. A request had been made for multiple medications and was not certified in the pre-authorization process on August 19, 2013.

IMR ISSUES, DECISIONS AND RATIONALES

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

RETROSPECTIVE REQUEST FOR 1 PRESCRIPTION FOR FLUTICASONE 50MCG #16 FOR 6/28/2013: 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 (ODG) pulmonary chapter, updated February 24, 2014.

Decision rationale: This is noted as a first-line choice for the treatment of this unrelated, ordinary disease of life comorbidity asthma. The medical records presented for review did not indicate that this is a diagnosis in this particular clinical situation. Furthermore, there were no physical examination citations indicating that this diagnosis existed in this injured worker. The listed diagnoses include cervical radiculitis, lumbar radiculopathy, the pain, shoulder pain, diabetes, carpal tunnel syndrome and migraine headaches. Therefore, based on this complete lack of medical information, this is not medically necessary.

RETROSPECTIVE REQUEST FOR 1 PRESCRIPTION FOR SUCRALFATE 1MG #120 FOR 6/28/2013: 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 Other Medical Treatment Guideline or Medical Evidence: Critical Care Medicine: March 2013 - Volume 41 - Issue 3 - pages 693-705.

Decision rationale: This medication is noted to be a Histamine-2 receptor antagonist and it is noted that protein pump inhibitors tend to be more effective. However, the progress notes presented did not indicate any history or complaints relative to gastrointestinal reflux disease (GERD) or that there were nonsteroidal anti-inflammatories causing any symptomatology. When noting the diagnosis was offered by the requesting provider, there were no references to any gastrointestinal disease processes. Therefore, based on the medical records presented for review, this is not medically necessary and appropriate.

RETROSPECTIVE REQUEST FOR 1 PRESCRIPTION FOR GERI-LANTA-LIQUID 200/200 #710 FOR 6/28/2013: 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 Other Medical Treatment Guideline or Medical Evidence: This combination preparation could not be found in any of the medical literature. There are no citations available discussing the utility of this solution.

Decision rationale: .The most recent progress notes and request for authorization address a topical salicylate preparation, a Lidoderm patch, and there is no discussion for a Geri-Lanta liquid. Furthermore, there were no noted complaints relative to the gastrointestinal system to suggest the need for such a preparation. Therefore, based on a complete lack of medical

information, this is determined that there is no medical indication and therefore is not medically necessary and appropriate.

RETROSPECTIVE REQUEST FOR 1 PRESCRIPTION FOR NIFEDIPINE ER 90MG #30 FOR 6/28/2013: 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 (ODG) diabetes chapter, updated February 20, 2014.

Decision rationale: This medication (a.k.a. Procardia) is a medication used to address cardiac issues. This is a calcium channel blocker used to address hypertension, Raynaud's syndrome and heart failure. The progress notes presented for review did not indicate that any of these diagnoses exist. Therefore, based on a complete lack of medical records, there is no medical necessity established for this preparation. There was no indication that these issues have been addressed. This would reinforce that there is no medical necessity established in the medical records for review and therefore the request is not medically necessary and appropriate.

RETROSPECTIVE REQUEST FOR 1 PRESCRIPTION FOR KETOP 20% LID 5% CYCL 1% FOR 6/28/2013: 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 Page(s): 111-113.

Decision rationale: California Medical Treatment Utilization Schedule guidelines state that topical analgesics are "largely experimental" and that "any compound product that contains at least one drug (or drug class) that is not recommended, is not recommended". The guidelines note there was little evidence to support the use of topical NSAIDs for treatment of the above noted diagnosis. Additionally, the guidelines state there is no evidence to support the use of topical cyclobenzaprine (muscle relaxant) and advise against the addition of cyclobenzaprine to other agents. Therefore, this request is not considered medically necessary.

RETROSPECTIVE REQUEST FOR 1 PRESCRIPTION FOR ADVAIR DISKUS 250/50 #60 6/28/2013: 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 (ODG) pulmonary chapter, updated February 24, 2014.

Decision rationale: As noted in the Official Disability Guidelines this medication (a.k.a. fluticasone) is for the treatment of asthma. This is noted as a first-line choice for the treatment of this unrelated, ordinary disease of life comorbidity. The medical records presented for review did not indicate that this was a diagnosis in this particular clinical situation. Furthermore, there were no physical examination citations indicating that this diagnosis existed in this injured worker. The listed diagnoses included cervical radiculitis, lumbar radiculopathy, shoulder pain, diabetes, carpal tunnel syndrome and migraine headaches. Therefore, based on this complete lack of medical information, this is not medically necessary.

RETROSPECTIVE REQUEST FOR 1 PRESCRIPTION FOR AMOLDIPINE BESYLATE 5MG #30 FOR 6/28/2013: 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 Other Medical Treatment Guideline or Medical Evidence: Critical Care Medicine: March 2013 - Volume 41 - Issue 3 - pages 693-705.

Decision rationale: This medication is noted to be a Histamine-2 receptor antagonist and it is noted that protein pump inhibitors tend to be more effective. However, the progress notes presented did not indicate any history or complaints relative to gastrointestinal reflux disease (GERD) or that there were nonsteroidal anti-inflammatories causing any symptomatology. When noting the diagnosis was offered by the requesting provider, there were no references to any gastrointestinal disease processes. Therefore, based on the medical records presented for review, this is not medically necessary.

RETROSPECTIVE REQUEST FOR 1 PRESCRIPTION FOR CRESTOR 10MG #30 FOR 6/28/2013: 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 Other Medical Treatment Guideline or Medical Evidence: Aggarwal, RK; Showkathali, R (June 2013). "Rosuvastatin calcium in acute coronary syndromes". Expert Opinion on Pharmacotherapy 14 (9): 1215-1227.

Decision rationale: This medication (a.k.a. rosuvastatin) is a statin medication aimed at reducing cholesterol in the bloodstream. This is addressing the cardiovascular disease. The progress note presented for review did not list any kind of cardiovascular disease. Therefore, based on the limited medical records presented for review, no medical necessity was established

to treat this ordinary disease of life. In that this medication has been approved and did address hypercholesterolemia, there is no medical necessity established for this medication and therefore it is not medically necessary and appropriate.

RETROSPECTIVE REQUEST FOR 1 PRESCRIPTION FOR LISINOPRIL 40MG #30 FOR 6/28/2013: 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 (ODG) diabetes chapter updated February 20, 2014.

Decision rationale: This medication (a.k.a. Procardia) is a medication used to address cardiac issues. This is a calcium channel blocker used to address hypertension, Raynaud's syndrome and heart failure. The progress notes, presented for review, did not indicate that any of these diagnoses existed. Therefore, based on a complete lack of medical records, there is no medical necessity established for this preparation. There was no indication that these issues have been addressed. This would reinforce that there is no medical necessity established in the medical records for review and therefore the request is not medically necessary and appropriate.

RETROSPECTIVE REQUEST FOR 1 PRESCRIPTION FOR PRO AIR HFA 90MCG #8.5 FOR 6/28/2013: 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 (ODG) pulmonary chapter, updated February 24, 2014.

Decision rationale: As noted in the Official Disability Guidelines this medication is for the treatment of asthma. The medication is also known as albuterol, an aerosol used to treat asthma. This is noted as a first-line choice for the treatment of this unrelated, ordinary disease of life comorbidity. The medical records presented for review did not indicate that this as a diagnosis in this particular clinical situation. Furthermore, there were no physical examination citations indicating that this diagnosis existed in this injured worker. The listed diagnoses include cervical radiculitis, lumbar radiculopathy, shoulder pain, diabetes, carpal tunnel syndrome and migraine headaches. Therefore, based on this complete lack of medical information, this is not medically necessary