

Case Number:	CM13-0029294		
Date Assigned:	03/19/2014	Date of Injury:	11/05/2008
Decision Date:	08/29/2014	UR Denial Date:	08/29/2013
Priority:	Standard	Application Received:	09/25/2013

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 Anesthesiologist Pain Medicine and is licensed to practice in Florida. 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 58-year-old female who reported injury on 11/05/2008. The documentation indicated the injured worker was utilizing Anaprox, Nexium, Imitrex, Imitrex injections, and Percocet as of 04/2013. The documentation indicated the injured worker underwent radiographs of the cervical spine. The documentation of 07/26/2013 revealed the injured worker had pain in the right shoulder and bilateral knees. The injured worker was noted to have Orthovisc injections that were helping with the knee pain. The injured worker had tenderness to palpation in the rotator cuff muscles and generalized weakness throughout motion of the right shoulder. The injured worker had bilateral knee crepitus and pain throughout motion. The injured worker had tenderness to palpation in the joint line. Swelling was noted. The diagnoses included impingement syndrome right shoulder with tendinitis and osteoarthritis bilateral knees. The treatment plan included a continuation of the home exercise program. There was no DWC Form RFA or PR-2 submitted for the requested medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

IMITREX: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation
<http://www.nlm.nih.gov/medlineplus/druginfo/meds/a601116.html>.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Head Chapter, Triptans.

Decision rationale: The Official Disability Guidelines recommend triptans for migraine sufferers. The clinical documentation submitted for review indicated the injured worker had utilized the medication since at least early 2013. There was a lack of documentation of objective functional benefit that was received. The request as submitted failed to indicate the frequency, quantity, and strength for the requested medication. Given the above, the request for Imitrex is not medically necessary.

ANAPROX: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 67-73.

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

Decision rationale: The California MTUS Guidelines recommend NSAIDs for the short term symptomatic treatment of pain and inflammation. There should be documentation of objective functional improvement and an objective decrease in pain. The clinical documentation submitted for review indicated the injured worker had utilized this type of medication since early 2013. There was a lack of documentation of objective functional benefit and documentation the injured worker had an objective decrease in pain. The request as submitted failed to indicate the frequency, quantity, and strength for the requested medication. Given the above, the request for Anaprox is not medically necessary.

PROTONIX: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68.

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

Decision rationale: The California MTUS Guidelines recommend PPIs for the treatment of dyspepsia secondary to NSAID therapy. The clinical documentation submitted for review indicated the injured worker had utilized medications in this classification since early 2013. There was a lack of documentation of objective functional benefit. There was a lack of documentation indicating the injured worker had signs or symptoms of dyspepsia. The request as submitted failed to indicate the frequency, quantity, and strength for the requested medication. Additionally, as the request for Anaprox was found to be not medically necessary, the request for Protonix is not medically necessary.

FLEXERIL: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril) Page(s): 41,64.

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

Decision rationale: The California MTUS Guidelines recommend muscle relaxants as a second line option for the short term treatment of acute pain. Their use is recommended for less than 3 weeks. There was a lack of objective findings to support the use of this medication. The duration of use could not be established through supplied documentation. There was a lack of documentation of objective functional benefit that was received. The request as submitted failed to include the frequency, quantity, and strength for the requested medication. Given the above, the request for Flexeril is not medically necessary.

PERCOCET 5-325MG: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 91.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic pain, ongoing management Page(s): 78.

Decision rationale: The California MTUS Guidelines recommend opioids for the treatment of chronic pain. There should be documentation of objective functional benefit and an objective decrease in pain, as well as documentation the injured worker is being monitored for aberrant drug behavior and side effects. The clinical documentation submitted for review failed to meet the above criteria. The request as submitted failed to indicate the frequency, quantity, and strength for the requested medication. Given the above, the request for Percocet 5/325 is not medically necessary.