

Case Number:	CM13-0036416		
Date Assigned:	03/21/2014	Date of Injury:	01/26/2011
Decision Date:	07/07/2014	UR Denial Date:	10/02/2013
Priority:	Standard	Application Received:	10/21/2013

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, 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. 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 51-year-old female who reported an injury on 01/26/2011. The mechanism of injury was not stated. Current diagnoses include status post lumbar spine decompression and fusion, chronic low back pain, postoperative radiculitis in the left lower extremity, left shoulder strain, left shoulder impingement syndrome, partial rotator cuff tear, and depression. This is a retrospective review for prescription medication issued on 09/30/2013. However, there was no physician progress report submitted on the requesting date of 09/30/2013. The latest physician progress report submitted for this review is documented on 04/08/2014. The injured worker reported left heel pain as well as right lower extremity weakness. Physical examination revealed positive tenderness over the paracervical musculature, intact sensation, 5/5 motor strength in bilateral upper extremities, positive tenderness in the paralumbar musculature, positive muscle spasming in the paralumbar musculature, limited lumbar range of motion, positive Neer and Hawkins testing on the left, and 4/5 strength in the bilateral lower extremities. Treatment recommendations included continuation of cyclobenzaprine, diclofenac XR, omeprazole, ondansetron, and tramadol ER.

IMR ISSUES, DECISIONS AND RATIONALES

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

DICLOFENAC XR 100MG #30 (DOS:09/30/13): 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: California MTUS Guidelines indicate that 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 treatment after acetaminophen. The injured worker has continuously utilized this medication. Despite ongoing use, the injured worker continues to report persistent pain. There is no evidence of objective functional improvement. There is also no frequency listed in the current request. Therefore, the request is not medically necessary.

OMEPRAZOLE 20MG #60 (DOS: 09/30/2013): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS-GIT SYMPTOMS.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68-69.

Decision rationale: California MTUS Guidelines indicate 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 evidence of cardiovascular disease or increased risk factors for gastrointestinal events. Therefore, the injured worker does not meet criteria for the requested medication. There is also no frequency listed in the current request. As such, the request is not medically necessary.

TRAMADOL ER 150MG #30 (DOS: 09/30/2013): Upheld

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

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

Decision rationale: California MTUS Guidelines indicate that 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. The injured worker has continuously utilized this medication. Despite ongoing use, there is no evidence of objective functional improvement. There is also no frequency listed in the current request. As such, the request is not medically necessary.