

Case Number:	CM13-0043667		
Date Assigned:	12/27/2013	Date of Injury:	08/27/1981
Decision Date:	07/09/2014	UR Denial Date:	10/18/2013
Priority:	Standard	Application Received:	10/25/2013

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 Internal Medicine 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 an 81-year-old male who reported an injury on 08/27/1981. The mechanism of injury was not specifically stated. Current diagnoses include hypertension, diabetes, peptic ulcer disease, GERD, blindness, IBS, dyslipidemia, sleep disorder, mechanical falls, headaches, fibromyalgia, umbilical hernia, atherosclerotic cardiovascular disease, chiropractic issues, and psychiatric diagnoses. The injured worker was evaluated on 09/11/2013. The injured worker reported a flare-up of fibromyalgia as well as complaints of loose stools. Current medications include NovoLog and Lantus insulin, Benazepril, Niaspan, Lovastatin, Tramadol, Gabapentin, and Zofran. Physical examination on that date revealed a blood pressure of 120/80, a heart rate of 72, a respiratory rate of 15, diminished hearing bilaterally, clear lung sounds to auscultation, normal bowel sounds, and an abnormal neurologic examination secondary to blindness and gait. Laboratory studies indicated a hemoglobin A1C of 7.1. It is noted that the injured worker remains permanent and stationary from an internal medicine point of view. Treatment recommendations at that time included a continuation of the current medication regimen with a new prescription for Imodium.

IMR ISSUES, DECISIONS AND RATIONALES

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

RETROSPECTIVE PRESCRIPTION OF ACARBOSE 25MG, #120 (DOS: 7/3/13): 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 www.nlm.nih.gov. U.S. National Library of Medicine. U.S. Department of Health and Human Services National Institutes of Health. Updated: 25 June 2014.

Decision rationale: Acarbose is used to treat type 2 diabetes. Acarbose works by slowing the action of certain chemicals that break down food to release glucose into the body. As per the documentation submitted, there is no indication of this injured worker's current utilization of this medication. There was no physician progress report submitted on the requesting date of 07/03/2013. There is also no frequency listed in the current request. Therefore, the request is not medically necessary.

RETROSPECTIVE PRESCRIPTION OF BD INSULIN SYRINGE 1/2ML, #100 (DOS: 7/3/13): 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) Knee & Leg Chapter, Durable Medical Equipment.

Decision rationale: Official Disability Guidelines state durable medical equipment is recommended generally if there is a medical need and if the device or equipment meets Medicare's definition of durable medical equipment. The injured worker does maintain a diagnosis of insulin dependent diabetes mellitus. The injured worker does currently utilize insulin medication. However, there was no physician progress report submitted on the requesting date of 07/03/2013. Therefore, the medical necessity has not been established. As such, the request is not medically necessary.

RETROSPECTIVE PRESCRIPTION OF GLIPIZIDE 5MG, #60 (DOS: 7/3/13): 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, Glipizide (Glucotrol) and www.nlm.nih.gov. U.S. National Library of Medicine. U.S. Department of Health and Human Services National Institutes of Health. Updated: 25 June 2014.

Decision rationale: Official Disability Guidelines state Glipizide is not recommended as a first line choice. Glipizide is used along with diet and exercise, and sometimes other medications, to treat type 2 diabetes. There was no physician progress report submitted on the requesting date of 07/03/2013. There is no evidence of this injured worker's current utilization of this medication.

There is also no frequency listed in the current request. As such, the request is not medically necessary.

RETROSPECTIVE PRESCRIPTION OF DEX4 GLUCOSE 4GM TABLET, #20 (DOS: 7/31/13): 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) Chronic Pain Chapter, Medical Food.

Decision rationale: Official Disability Guidelines state medical food is a food which is formulated to be consumed or administered enterally under the supervision of a physician and which is intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements are established by medical evaluation. There was no physician progress report submitted on the requesting date of 07/31/2013. Therefore, the medical necessity for the requested medication has not been established. As such, the request is not medically necessary.

RETROSPECTIVE PRESCRIPTION OF NOVOLOG FLEXPEN SYRINGE 100U/M, #45 (DOS: 7/3/13; 7/30/13): 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, Pre-filled insulin pen.

Decision rationale: Official Disability Guidelines state pre-filled insulin pens are recommended for type 1 or type 2 diabetes. FlexPen delivered consistent and accurate doses of insulin. There was no physician progress report submitted on the requesting date of 07/03/2013. Therefore, the medical necessity for the requested medication has not been established. There is also no frequency listed in the current request. As such, the request is not medically necessary.

RETROSPECTIVE PRESCRIPTION OF LANTUS SOLOSTAR 100ML, #45 (DOS: 7/3/13, 7/30/13, 8/28/13): 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, Insulin.

Decision rationale: Official Disability Guidelines recommend insulin for treatment of type 1 diabetes, or for type 2 diabetes if glycemic goals are not reached by oral anti-diabetics. There is no documentation of a failure to respond to oral anti-diabetics prior to the initiation of insulin. There was no physician progress report submitted on the requesting date. There was also no frequency listed in the current request. As such, the request is not medically necessary.

RETROSPECTIVE PRESCRIPTION OF LOVASTAIN 40MG, #90 (DOS: 7/3/13, 7/30/13, 8/28/13): 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, Statins.

Decision rationale: Official Disability Guidelines do not recommend statins as a first line treatment for diabetics. Statins may be a treatment in the absence of contraindications, but recent studies have associated increased risk of diabetes with the use of all types of statins. Therefore, the current request cannot be determined as medically appropriate. There was also no physician progress report submitted on the requesting date. There is no frequency listed in the current request. As such, the request is not medically necessary.

RETROSPECTIVE PRESCRIPTION FOR KETOPRO/LIDO/CYCLO 20/5/1%, 180GM (DOS: 7/3/13, 7/30/13, 8/28/13): 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 MTUS 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. The only FDA approved topical NSAID is Diclofenac. Cyclobenzaprine is not recommended, as there is no evidence for the use of any muscle relaxant as a topical product. There is also no frequency listed in the current request. As such, the request is not medically necessary.

RETROSPECTIVE PRESCRIPTION OF BENAZEPRIL HCL 40MG, #90 (DOS: 7/3/13, 7/30/13, 8/28/13): 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, Hypertension Treatment.

Decision rationale: Official Disability Guidelines state hypertension treatment is recommended after lifestyle modification with diet and exercise. Benazepril is a first line, first choice renin-angiotensin aldosterone system blocker. As per the documentation submitted, there was no physician progress report submitted on the requesting date. There is no evidence of a failure to respond to lifestyle modifications. There is also no frequency listed in the current request. As such, the request is not medically necessary.

RETROSPECTIVE PRESCRIPTION FOR VITAMIN D 1.25MG SOFTGEL 50000 UNIT, #3 (DOS: 7/3/13, 7/30/13, 8/28/13): 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) Chronic Pain Chapter, Vitamin D.

Decision rationale: Official Disability Guidelines recommend vitamin D in chronic pain patients and as a supplementation if necessary. There is no documentation of this patient's active utilization of this medication. There is no physician progress report submitted on the requesting date. There is also no frequency listed in the current request. As such, the request is not medically necessary.

RETROSPECTIVE REQUEST FOR TECHLITE BLOOD LANCETS #300 (DOS: 7/3/13, 7/30/13, 8/28/13): 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) Knee & Leg Chapter, Durable Medical Equipment.

Decision rationale: Official Disability Guidelines state durable medical equipment is recommended generally if there is a medical need and if the device or equipment meets Medicare's definition of durable medical equipment. The injured worker does maintain a diagnosis of insulin dependent diabetes mellitus. The injured worker does currently utilize insulin medication. However, there was no physician progress report submitted on the requesting date of 07/03/2013. Therefore, the medical necessity has not been established. As such, the request is not medically necessary.

RETROSPECTIVE PRESCRIPTION OF CIMETIDINE 800MG, #360, (DOS: 7/3/13, 7/30/13, 8/28/13): 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 www.nlm.nih.gov. U.S. National Library of Medicine. U.S. Department of Health and Human Services National Institutes of Health. Updated: 25 June 2014.

Decision rationale: Cimetidine is used to treat ulcers, GERD, and conditions where the stomach produces too much acid. The injured worker does maintain a diagnosis of gastroesophageal reflux disease. However, there was no physician progress report submitted on the requesting date. There is no evidence of this injured worker's current utilization of this medication. There is also no frequency listed in the current request. As such, the request is not medically necessary.

RETROSPECTIVE REQUEST FOR 300 BD PEN NEEDLE NANO 32GX5 (DOS: 7/3/13, 7/30/13, 8/28/13): 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) Knee & Leg Chapter, Durable Medical Equipment.

Decision rationale: Official Disability Guidelines state durable medical equipment is recommended generally is there if a medical need and if the device or equipment meets Medicare's definition of durable medical equipment. The injured worker does maintain a diagnosis of insulin dependent diabetes mellitus. The injured worker does currently utilize insulin medication. However, there was no physician progress report submitted on the requesting date of 07/03/2013. Therefore, the medical necessity has not been established. As such, the request is not medically necessary.

RETROSPECTIVE PRESCRIPTION OF PRESERVISION AREDS 2 SOFT 250-2.5, #360 (DOS: 7/3/13, 7/30/13, 8/28/13): 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) Knee & Leg Chapter, Durable Medical Equipment.

Decision rationale: Official Disability Guidelines state durable medical equipment is recommended generally is there if a medical need and if the device or equipment meets Medicare's definition of durable medical equipment. The injured worker does maintain a diagnosis of insulin dependent diabetes mellitus. The injured worker does currently utilize insulin medication. However, there was no physician progress report submitted on the requesting date of 07/03/2013. Therefore, the medical necessity has not been established. As such, the request is not medically necessary.

RETROSPECTIVE PRESCRIPTION FOR DOK 250MG, #300 (DOS: 7/3/13, 7/30/13, 8/28/13): 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): 77. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Opioid Induced Constipation Treatment.

Decision rationale: California MTUS Guidelines state prophylactic treatment of constipation should be initiated when also initiating opioid therapy. Official Disability Guidelines state first line treatment for opioid-induced constipation includes increasing physical activity, maintaining appropriate hydration, and advising the patient to follow a proper diet. The injured worker does not maintain a diagnosis of chronic constipation. The injured worker currently reports several loose stools per day. There was no physician progress report submitted on the requesting date. There is also no frequency listed in the current request. Based on the clinical information received, the request is not medically necessary.