

Case Number:	CM13-0048039		
Date Assigned:	12/27/2013	Date of Injury:	09/26/2011
Decision Date:	04/25/2014	UR Denial Date:	10/24/2013
Priority:	Standard	Application Received:	11/04/2013

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 and 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 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 patient is a 48-year-old male who reported an injury on 09/26/2011 due to cumulative trauma while performing normal job duties. The patient's treatment history included physical therapy, chiropractic care, traction, and multiple medications. The patient's most recent clinical evaluation documented that the patient had decreased lumbosacral range of motion, a positive bilateral Kemp's test, a positive bilateral piriformis test, a positive left-sided Yeoman's test, decreased sensation in the S1 dermatome, and low back pain radiating into the bilateral lower extremities. The patient's diagnoses included low back pain, lumbar radiculitis, and segmental dysfunction. The patient's treatment plan included continuation of physical therapy and medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

CYLOBENZAPRINE 7.5 MG #120: Upheld

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

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

Decision rationale: The requested Cyclobenzaprine 7.5 MG #120 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends this medication for acute exacerbations in moderate to severe pain and muscle spasming. The clinical documentation dated 10/17/2013 did not include an adequate assessment of the patient's physical findings. There were no quantitative assessments provided. Therefore, the efficacy of this medication cannot be determined. As such, the requested Cyclobenzaprine 7.5 M #120 is not medically necessary or appropriate.

ONDANSETRON 8 MG #60: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guideilnes, Pain Chapter

Decision rationale: The requested Ondansetron 8 MG #60 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not address this medication. Official Disability Guidelines recommend this medication for patients who have acute gastritis or gastrointestinal upset related to chemotherapy or surgical intervention. The clinical documentation submitted for review does not provide any evidence that the patient has recently undergone any cancer-related treatments or surgical interventions. Official Disability Guidelines do not recommend the use of anti-emetics in the treatment of nausea related side effects due to medication usage. Therefore, the use of this medication would not be supported. As such, the requested Ondansetron 8 MG #60 is noted medically necessary or appropriate.

OMEPRAZOLE EXTENDED RELEASE 20MG #120.: Upheld

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

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

Decision rationale: The requested Omeprazole extended release 20 MG #120 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends the use of this medication as a gastrointestinal protectant for patients who are at risk for gastrointestinal symptoms related to medication usage. The clinical documentation submitted for review does not provide an adequate assessment of the patient's gastrointestinal system to support that they are at risk for developing gastrointestinal events related to medication usage. There is no physical examination for the request for authorization dated 10/17/2013. Therefore, the need for this medication is not clearly established. As such, the requested Omeprazole extended release 20 MG #120 is not medically necessary or appropriate.

KETOPROFEN CREAM: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 49.

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

Decision rationale: The requested Ketoprofen cream is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not support the use of Ketoprofen as a topical analgesic. This medication is not FDA approved to treat neuropathic pain. Therefore, continued use would not be supported. As such, the requested Ketoprofen cream is not medically necessary or appropriate.

COOLEEZE: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 49.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Salicylate Topicals Section Page(s): 105.

Decision rationale: The requested Cooleeze is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends short courses of methyl salicylate or menthol as appropriate for patients with osteoarthritic pain. The clinical documentation submitted for review does not provide an adequate assessment for the request for authorization dated 10/17/2013 to support that the patient has osteoarthritic-related pain. Additionally, the request as it is written does not provide a duration, frequency, or dosage. Therefore, the appropriateness of this medication Final Determination Letter for IMR Case Number [REDACTED] cannot be determined. As such, the requested Cooleeze is not medically necessary or appropriate.