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| Case Number: | CM13-0050997 | | |
| Date Assigned: | 12/27/2013 | Date of Injury: | 06/06/2005 |
| Decision Date: | 03/18/2014 | UR Denial Date: | 10/31/2013 |
| Priority: | Standard | Application Received: | 11/13/2013 |

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 Anesthesiology, has a subspecialty in Pain Management 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 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 patient is a 69-year-old male who reported an injury on 06/06/2005. The patient is diagnosed with knee arthritis, cervical spine strain, lumbar spine strain, and history of gout. The patient was recently seen by [REDACTED] on 10/14/2013. The patient reported persistent pain in the lumbar spine and right knee. Physical examination revealed mild joint line tenderness. Treatment recommendations included a return office visit in 3 months.

IMR ISSUES, DECISIONS AND RATIONALES

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

RANITIDINE 150MG #30: Upheld

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

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

Decision rationale: The Physician Reviewer's decision rationale: The California MTUS Guidelines state 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 nonselective NSAID. There is no documentation of cardiovascular disease or increased risk factors for gastrointestinal events.

Therefore, the patient does not meet criteria for the requested medication. As such, the request is noncertified.

HYDROCODONE/APAP 5/325MG #30: Upheld

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

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

Decision rationale: The Physician Reviewer's decision rationale: The California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Baseline pain and functional assessments should be made. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. As per the documentation submitted, there is no evidence of a significant musculoskeletal or neurological deficit that may warrant the need for ongoing opioid management. There is also no indication of a failure to respond to non-opioid analgesics. Based on the clinical information received, the request is noncertified.

THERAMINE #180 (2 BOTTLES): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

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: The Physician Reviewer's decision rationale: Official Disability Guidelines state medical food is a food which is formulated to be consumed or administered entirely 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, based on recognized scientific principles, or established by medical evaluation. The medical necessity for the requested medication has not been established. Therefore, the request is noncertified.

DENDRACIN LOTION 120ML: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

Decision rationale: The Physician Reviewer's decision rationale: The California MTUS Guidelines state topical analgesics are largely experimental in use, with few randomized control

trials to determine efficacy or safety. They are primary recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is no documentation of neuropathic pain upon physical examination. There is also no evidence of a failure to respond to first-line oral medication prior to the request for a topical analgesic. Based on the clinical information received, the request is noncertified.

SENTRA PM #60: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

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, Insomnia Treatment.

Decision rationale: The Physician Reviewer's decision rationale: Official Disability Guidelines state insomnia treatment is recommended based on etiology. Empirically supported treatment includes stimulus control, progressive muscle relaxation, and paradoxical intention. There is no evidence of chronic insomnia or sleep disturbance. There is also no documentation of a failure to respond to nonpharmacologic treatment. Based on the clinical information received, the request is noncertified.

NAPROXEN 250MG #60: 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: The Physician Reviewer's decision rationale: The California MTUS Guidelines state NSAIDs are recommended for osteoarthritis at the lowest dose for the shortest period in patients with moderate to severe pain. Acetaminophen may be considered for initial therapy for patients with mild to moderate pain. As per the documentation submitted, the patient does not maintain a diagnosis of osteoarthritis. There is no evidence of a failure to respond to first-line treatment with acetaminophen, as recommended by the California MTUS Guidelines. The medical necessity for the requested medication has not been established. Therefore, the request is noncertified.