

Case Number:	CM13-0062390		
Date Assigned:	04/30/2014	Date of Injury:	07/28/2010
Decision Date:	06/12/2014	UR Denial Date:	11/18/2013
Priority:	Standard	Application Received:	12/06/2013

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 & Rehabilitation and is licensed to practice in Illinois. 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 57 year old male with a reported date of injury on 07/28/2012; the mechanism of injury was not provided. Diagnoses included cervical and lumbosacral radiculopathy. The clinical noted dated 09/26/2103 noted subjective complaints included 6/10 chronic pain to the lumbar spine with radiation to the lower extremities bilaterally. The objective findings included noted tenderness over the paravertebral muscles of the lumbar spine with spasms, decreased range of motion on flexion and extension, and decreased sensation along the L4 dermatomal distributions bilaterally. A clinical note dated 10/24/2013 noted that the injured worker previously received epidural injections of unknown date and that he was still complaining of residual pain. It was also noted the injured worker had not been provided any medications and has been performing his work-related activities efficiently. The request for authorization form was not provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

KETOPROFEN: 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 NSAIDS Page(s): 68.

Decision rationale: The California MTUS guidelines state that NSAIDs are recommended for chronic low back pain as an option for short term symptomatic relief. It was noted that the injured worker had complaints to include 6/10 chronic pain to the lumbar spine with radiation to the lower extremities bilaterally. The objective findings included noted tenderness over the paravertebral muscles of the lumbar spine with spasms, decreased range of motion on flexion and extension, and decreased sensation along the L4 dermatomal distributions bilaterally. It was also noted that the injured worker had received epidural injections of unknown date and that he was still complaining of residual pain. The injured worker had not been provided any medications and has been performing his work-related activities efficiently. In this case, the medical necessity for this medication has not been established. Based on the available documentation provided it remains unclear what the plan of treatment is for this medication to include duration, frequency, and dosage. Therefore, the request is not medically necessary.

TRAMADOL: 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 OPIOIDS Page(s): 75.

Decision rationale: The California MTUS guidelines state that central acting analgesics can be effective in managing neuropathic pain. However, the medical necessity for this medication has not been established. Based on the available documentation provided it remains unclear what the plan of treatment is for this medication to include duration, frequency, and dosage. Therefore, the request is not medically necessary.

LIDOCAINE SPRAY: 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 TOPICAL ANALGESICS Page(s): 112.

Decision rationale: The California MTUS guidelines state that the Lidocaine in the form of a topical analgesic is recommended for the treatment of neuropathic pain. The guidelines also state that lidocaine in the form of Lidoderm (dermal patches) is the only FDA approved topical formulation of lidocaine; all others are not recommended. Additionally, based on the available documentation provided it remains unclear what the plan of treatment is for this medication to include duration, frequency, and dosage. Therefore, medical necessity is not established.

PROTONIX: 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 NSAIDS, GI SYMPTOMS & CARDIOVASCULAR RISK Page(s): 68-69.

Decision rationale: The California MTUS guidelines recommend proton pump inhibitors for use in patients at intermediate risk for gastrointestinal events. However, the medical necessity of this medication cannot be determined due to the lack of objective physical findings or documentation of a history of GI symptomatology. Additionally, it remains unclear what the unclear what the plan of treatment is for this medication to include duration, frequency, and dosage. The medical necessity is not established.