

Case Number:	CM14-0008302		
Date Assigned:	02/10/2014	Date of Injury:	04/22/2007
Decision Date:	07/10/2014	UR Denial Date:	01/07/2014
Priority:	Standard	Application Received:	01/21/2014

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, has a subspecialty in Pain Medicine and is licensed to practice in Minnesota. 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 47-year-old male who reported an injury on 04/22/2007. The mechanism of injury involved heavy lifting. Current diagnoses include obesity, sprain and strain of the lumbar region, and thoracic or lumbosacral neuritis or radiculitis. The latest physician progress report submitted for this review is documented on 12/18/2013. The injured worker was status post removal of lumbar hardware on 12/03/2013. The injured worker reported significant back weakness. Physical examination indicated a healing incision at the site of the surgical intervention, spasm, tenderness, guarding, decreased sensation in the L5 and S1 dermatomes, and an antalgic gait. The injured worker utilized a back brace and a 4-point walker. Treatment recommendations at that time included continuation of conservative medical management.

IMR ISSUES, DECISIONS AND RATIONALES

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

GABAPENTIN 20MG (QUANTITY UNSPECIFIED) QTY: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 18-19, 49, 113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 16-18.

Decision rationale: California MTUS Guidelines state anti-epilepsy drugs are recommended for neuropathic pain. There is no indication that this injured worker is currently utilizing this medication. There is also no specific quantity or frequency listed in the current request. As such, the request is not medically appropriate. Therefore, the request is not medically necessary.

HYDROCORDONE 10/325MG (QUANTITY UNSPECIFIED) QTY: 1.00: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM); Occupational Medicine Practice Guidelines; Evaluation and Management of Common Health Problems and Functional Recovery in Workers, pg. 116.

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

Decision rationale: California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of nonopioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. There is no documentation of this injured worker's active utilization of this medication. There is also no frequency or specified quantity listed in the current request. As such, the request is not medically necessary.

MORPHINE 4MG (QUALITY UNSPECIFIED) QTY: 1.00: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM); Occupational Medicine Practice Guidelines; Evaluation and Management of Common Health Problems and Functional Recovery in Workers, pg. 116.

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

Decision rationale: California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of nonopioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. There is no documentation of this injured worker's active utilization of this medication. There is also no frequency or specified quantity listed in the current request. As such, the request is not medically necessary.

PRILOSEC 20MG (QUANTITY UNSPECIFIED) QTY:1.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI SYMPTOMS & CARDIOVASCULAR RISK Page(s): 68-69.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 16-18.

Decision rationale: 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 evidence of cardiovascular disease or increased risk factors for gastrointestinal events. There is also no frequency or specified quantity listed in the request. As such, the request is not medically necessary.

MILK OF MAGNESIA 30ML (QUANTITY UNSPECIFIED) QTY: 1.00: 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) CHRONIC PAIN CHAPTER, 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 medical necessity for the requested medication has not been established. There is also no specific quantity or frequency listed in the current request. As such the request is not medically necessary.

BENADRYL (STRENGTH & QUANTITY UNSPECIFIED) QTY: 1.00: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Work Loss Data Institute, 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: Official Disability Guidelines state Diphenhydramine is a sedating antihistamine, often utilized as an over-the-counter medication for insomnia treatment. There is no indication of chronic insomnia or a chronic condition where an antihistamine is necessary. There is also no specific quantity or frequency listed in the request. As such, the request is not medically necessary.

ZOLFRAN (STRENGTH & QUANTITY UNSPECIFIED) QTY: 1.00: 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, ONDANSETRON, ANTIEMETIC.

Decision rationale: Official Disability Guidelines state Zofran is not recommended for nausea and vomiting secondary to chronic opioid use. It has been FDA-approved for nausea and vomiting secondary to chemotherapy and radiation. Therefore, the injured worker does not meet criteria for the requested medication. There was also no strength, frequency, or quantity listed. As such, the request is not medically necessary.

AMBIEN (STRENGTH & QUANTITY UNSPECIFIED) QTY: 1.00: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Work Loss Data Institute 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: Official Disability Guidelines state insomnia treatment is recommended based on etiology. Ambien is indicated for the short-term treatment of insomnia with difficulty of sleep onset for 7 to 10 days. The injured worker does not maintain a diagnosis of chronic insomnia. There is also no strength, frequency, or quantity listed. As such, the request is not medically necessary.

INCENTIVE SPIROMETRY QTY: 1.00: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OTHER MEDICAL TREATMENT GUIDELINE OR MEDICAL EVIDENCE.

Decision rationale: An incentive spirometer is a device used to help keep lungs healthy after surgery or when a patient has a lung illness, such as pneumonia. The injured worker does not meet the above-mentioned criteria for the use of an incentive spirometer. As the medical necessity has not been established, the current request is not medically necessary.

SEQUENTIAL COMPRESSION PNEUMATIC BOOT DEVICES FOR BILATERAL LOWER EXTREMITIES AND CALVES QTY: 1.00: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Work Loss Data Institute, 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) KNEE & LEG CHAPTER, COMPRESSION GARMENTS.

Decision rationale: Official Disability Guidelines state good evidence for the use of compression is available; however, little is known about dosimetry and compression, for how long and at what level compression should be applied. While it is noted that the injured worker is status post lumbar hardware removal on 12/03/2013, there is no indication that the injured worker is at high risk for development of a deep vein thrombosis. As the medical necessity has not been established, the current request is not medically necessary.