

Case Number:	CM14-0100731		
Date Assigned:	07/30/2014	Date of Injury:	01/14/2012
Decision Date:	11/10/2014	UR Denial Date:	06/05/2014
Priority:	Standard	Application Received:	06/30/2014

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 Family Medicine and is licensed to practice in North Carolina. 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 59-year-old with a reported date of injury of 01/14/2012. The patient has the diagnoses of lumbar degenerative disc disease, lumbar radiculopathy and thoracic spine strain/sprain. Past treatment modalities have included acupuncture and physical therapy. Per the most recent progress notes provided for review by the primary treating physician dated 09/09/2014, the patient had complaints of continued and constant low back pain rated a 4-6/10. The physical exam noted no changes but an MRI from 07/14/2014 showed subtle loss of disc space at L3/4 and L4/5, disc bulge at L4/5 and L5/S1 and L4/5 borderline facet hypertrophy and central stenosis. Treatment plan recommendations included medial branch block and continuation of medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

Naproxen 550 mg; BID #60 Refill:1: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs(Non- Steroidal Anti-inflammatory Drugs) Page(s): Page 66-69.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAID Page(s): 71-73.

Decision rationale: This medication is recommended at the lowest possible dose for the shortest period of time. The duration of "shortest period of time" is not defined in the California MTUS. The patient has no mentioned cardiovascular, renovascular or gastrointestinal side-effects or risk factors. The dosage prescribed is within recommendations. The request is medically necessary and appropriate.

Prilosec 20mg; BID #60 Refill:1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 66-69, 78, 113.

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

Decision rationale: There is no supplied documentation that places this patient at intermediate or severe gastrointestinal risk that would require a use of a PPI with NSAID therapy. There is also no mention of separate gastrointestinal disease that would require the use of a PPI independent of NSAID use. For these reasons the criteria as set forth above have not been met for the use of the medication. The request is not medically necessary and appropriate.

Tramadol 50mg; TID #90 Refill:1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol (Ultram); Opioids Page(s): 66-69, 78, 113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 76-84.

Decision rationale: The long-term use of this medication is not recommended unless certain objective outcome measures have been met as defined above. There is no provided objective outcome measure that shows significant improvement in function while on the medication or a return to work. The most recent documentation states the patient's pain is a 4-6/10 on the VAS scale but fails to document a significant improvement in VAS score with the medication. For these reasons criteria for ongoing and continued use of the medication have not been met. The request is not medically necessary and appropriate.