

Case Number:	CM14-0102838		
Date Assigned:	07/30/2014	Date of Injury:	07/24/2006
Decision Date:	10/03/2014	UR Denial Date:	06/04/2014
Priority:	Standard	Application Received:	07/03/2014

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 and Rehabilitation and is licensed to practice in Nevada. 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 records presented for review indicate that this 45 year-old individual was reportedly injured on July 24, 2006. The mechanism of injury is not listed in these records reviewed. The most recent progress note, dated July 2, 2014 indicates that there are ongoing complaints of low back pain with lower extremity involvement. The physical examination demonstrated "no significant changes" and no particular positives were presented. Diagnostic imaging studies were not presented for review as well. Previous treatment includes lumbar fusion surgery, multiple medications, physical therapy, home exercise protocols and pain management interventions. A request had been made for multiple medications and was not certified in the pre-authorization process on June 4, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Biofreeze gel tube, three count: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) <Insert Section (for example Knee Low Back Chapter Updated August, 2014

Decision rationale: This preparation is not addressed in the MTUS. However, it is noted in the ODG and is under study. There are insufficient clinical evaluations presented to support the efficacy of this topical preparation. Therefore, based on the progress notes presented for review, noting there has not been any change in the overall clinical situation tempered by the parameters outlined in the ODG this is not medically necessary. Therefore, the request for Biofreeze gel tube, three count, is not medically necessary or appropriate.

Ibuprofen 800 mg/tab, 180 count: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Non-selective NSAIDs, Ibuprofen Page(s): 72.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 22 of 127.

Decision rationale: The progress notes presented for review indicate the injured employee is status post lumbar fusion. There is no inflammatory process that is being addressed. While noting that this medication has been indicated for chronic low back pain, this is more pretty intervention relative to signs and symptoms of osteoarthritis. Therefore, based on the clinical examination presented for review, tempered by the physical examination and the objective medical evidence presented for review there is no medical necessity established for this medication. Therefore, the request for Ibuprofen 800 mg/tab, 180 count, is not medically necessary or appropriate.

Omeprazole 20 mg/tab, ninety count: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms, and Cardiovascular Risk Page(s): 68-69.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68 of 127.

Decision rationale: When noting the date of injury, the injury sustained, the lack of a clinical indication for non-steroidal medication and that the gastric complaints are ameliorated with taking this medication with food, there is no clinical indication presented for the ongoing use of this protein pump inhibitor. Therefore based on the progress notes presented tempered by the parameters outlined in the MTUS this is not medically necessary. Therefore, the request for Omeprazole 20 mg/tab, ninety count, is not medically necessary or appropriate.

Ultracet 37.5/325 mg/tab, 360 count: 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), Opioids, specific drug list.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 82, 113 of 127..

Decision rationale: The California MTUS guidelines support the use of Tramadol (Ultram) for short-term use after there has been evidence of failure of a first-line option, evidence of moderate to severe pain, and documentation of improvement in function with the medication. A review of the available medical records fails to document any improvement in function or pain level with the previous use of Tramadol. There is no increase in functionality, decrease in pain, and this is being used on a chronic /indefinite protocol. As such, the request is not considered medically necessary as a standard outlined in the MTUS are not met. Therefore, the request for Ultracet 37.5/325 mg/tab, 360 count, is not medically necessary or appropriate.