

Case Number:	CM14-0105997		
Date Assigned:	07/30/2014	Date of Injury:	02/13/2012
Decision Date:	08/29/2014	UR Denial Date:	06/25/2014
Priority:	Standard	Application Received:	07/08/2014

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, 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 45-year-old female who reported an injury on 02/13/2012 due to pulling a twin mattress from a warehouse. On 05/23/2014, she reported neck and left shoulder pain, described as aching, burning, stabbing, and throbbing. A physical examination revealed tenderness over the left base of the occiput, upper trapezius, levator scapulae, and rhomboids, along with tenderness over the C6-7 to percussion. Documentation regarding diagnostic studies and surgical history was not provided for review. Her diagnoses included musculoligamentous sprain of the cervical spine with left upper extremity radiculitis. Medications included flurbiprofen/ranitidine 100/100 mg. past treatments included medications. The treatment plan was for ranitidine/flurbiprofen 100/100 mg 1 cap 2 to 3 times daily #90 times 3 refills, keratek gel 4 ounces apply a thin layer 2 to 3 times a day with 3 refills, and midazolam/melatonin 10/3 mg #30 with 1 cap every night at bedtime as needed times 3 refills. The Request for Authorization form and rationale for treatment were not provided for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ranitidine/Flurbiprofen 100/100mg 1 cap 2-3 times daily #90 x 3 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-72.

Decision rationale: The request for ranitidine/flurbiprofen 100/100 mg 1 cap 2 to 3 times daily #90 times 3 refills is not medically necessary. Per the clinical note dated 05/23/2014, the injured worker was noted to have tenderness over the C6-7, at the left base of the occiput, left upper trapezius, and levator scapulae and rhomboids. She was prescribed flurbiprofen/ranitidine 100/100 mg. The California MTUS Guidelines state that NSAIDs are specifically recommended for osteoarthritis including the knee and hip at the lowest dose for the shortest period in patients with moderate pain, for acute exacerbations of chronic back pain as a second line treatment after acetaminophen, for chronic low back pain recommended as an option for short-term symptomatic relief, and not recommended for neuropathic pain. Proton pump inhibitors are recommended to treatment dyspepsia secondary to NSAID therapy or for patients taking NSAID medications who have cardiovascular disease or significant risk factors for gastrointestinal events. Based on the clinical information submitted for review, the injured worker was noted to have been prescribed ranitidine/flurbiprofen 100/100 mg on 05/23/2014. There was a lack of documentation regarding objective functional improvement with the medication provided for review. In addition, there was no documentation indicating that the injured worker had complaints of dyspepsia with the use of this medication, cardiovascular disease, or significant risk factors for gastrointestinal events. Furthermore, there is no documentation showing that the injured worker tried the first line of treatment with acetaminophen and the request for a second line treatment medication is unclear. In the absence of this documentation, the request is not supported by the evidence-based guidelines. As such, the request is not medically necessary.

Keratek Gel 4oz apply a thin layer 2-3 times a day x 3 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-114.

Decision rationale: The request for keratek gel 4 ounces apply a thin layer 2 to 3 times a day times 3 refills is not medically necessary. Per the clinical note dated 05/23/2014, the injured worker reported neck and left shoulder pain described as aching, burning, stabbing, and throbbing. The California MTUS Guidelines state that topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Methyl salicylate is recommended by the guidelines as it has been shown to be better than placebo for chronic pain. Keratek gel contains menthol 16% and methyl salicylate 28%. However, it was noted that the injured worker had already been prescribed pain medications to address her pain and the use of a topical analgesic in addition to a pain medication is unclear. In addition, the intended location for the medication was not provided and is unclear. Without knowledge of the intended location for the medication, medical necessity could not be established; and therefore the request is not supported. Given the above, the request is not medically necessary.

Midazolam/Melatonin 10/3mg #30 1 capsule qhs (at bedtime) prn (as needed) x 3 refills:
Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 24.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

Decision rationale: The request for midazolam/melatonin 10/3 mg #30 with 1 capsule qhs (at bedtime prn (as needed) times 3 refills is not medically necessary. Per the clinical note dated 05/23/2014, the injured worker reported neck and left shoulder pain. A physical examination showed tenderness over the left base of the occiput, upper trapezius, levator scapulae, and rhomboids, along with tenderness over the C6-7 level. The California MTUS Guidelines state that benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. It is unclear if the medication being requested is a new medication or if the injured worker had been taking this medication as there was no documentation regarding the use of this medication. Without knowing if the injured worker had been using this medication prior to the request, the request would not be supported as it is only recommended for short-term treatment. In addition, the rationale for the medication is unclear as the injured worker was already prescribed a different medication to address her pain symptoms and there appears to be no evidence supporting the use of a benzodiazepine. Given the above, the request is not medically necessary.