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| Case Number: | CM14-0106524 | | |
| Date Assigned: | 09/16/2014 | Date of Injury: | 12/27/2011 |
| Decision Date: | 10/23/2014 | UR Denial Date: | 06/10/2014 |
| Priority: | Standard | Application Received: | 07/09/2014 |

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, has a subspecialty in Pain Medicine and is licensed to practice in California. 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 62 year-old female was reportedly injured on December 27, 2011. The mechanism of injury is noted as cumulative trauma and lifting boxes estimated by the claimant to weigh 60 pounds on the date of injury. The most recent progress note, dated June 6, 2014, indicates that there are ongoing complaints of neck, bilateral upper extremity, and low back symptoms. The physical examination demonstrated no evidence of muscle spasm or rigidity about the cervical spine. Tenderness palpation is noted along the midline and right cervical paraspinal muscles extending into the right trapezius and medial scapular region. Cervical range of motion is diminished. Cervical compression test is negative. Reflexes are absent in both upper extremities. Normal motor function is noted in both upper extremities. Neurologic function is intact in both upper extremities with no evidence radiculopathy. Examination of the shoulders reveals diminished range of motion, normal rotator cuff strength, and negative impingement testing on the right, but positive on the left. An examination of the lumbar spine did not occur. The lower extremities were not examined. Past medical history is significant for gastrointestinal complications. MRIs were previously obtained the knees which demonstrated arthritic changes from on the right knee than the left. Electrodiagnostic studies of the upper extremities demonstrated bilateral carpal tunnel syndrome. No additional radiology reports of them provided. Previous treatment includes braces, electrodiagnostic studies, advanced imaging, and oral medications. A request had been made for omeprazole, ondansetron, orphenadrine, and Terocin which were not certified in the pre-authorization process on June 10, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Omeprazole 20mg #120 1 PO 12H PRN: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68-69.

Decision rationale: The MTUS supports the use of proton pump inhibitors for individuals are concurrently utilizing anti-inflammatory medications and are at increased risk of G.I. complications or have a history of G.I. complications. The most recent clinical progress note notes no medical history of G.I. complications. Additionally, there is no indication that the claimant is currently utilizing NSAIDs. As such, the requested omeprazole is considered not medically necessary.

Ondansetron 8mg #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Drugs.com Notes FDA Approved

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (chronic); Ondansetron

Decision rationale: This medication is FDA approved for the treatment of nausea and vomiting secondary to chemotherapy, radiation treatments, postoperatively, an acute gastroenteritis. Based on the clinical documentation provided, there is not a clear indication for the utilization of this medication. The most recent review progress note does not document any complaints of nausea. The ODG recommends against the use of this medication in conjunction with chronic opioid medications. Given the lack of documentation provided by the treating clinician as well as the recommendation of the ODG the request is considered not medically necessary.

Orphenadrine Citrate #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63-66.

Decision rationale: The MTUS supports use of muscle relaxants as a 2nd line agent for the short-term management of acute exacerbations of chronic low back pain. Based on the clinical documentation provided, there is no evidence of muscle spasm on examination. As such there does not appear to be clear indication for the use of this medication. Additionally, the clinician

has not identified failure of first-line medications. This request is considered not medically necessary.

Terocin Patch #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics. Decision based on Non-MTUS Citation Drugs.com

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: Terocin is a topical preparation containing menthol, methyl salicylate, capsaicin, and lidocaine. MTUS indicates that topical analgesics are considered largely experimental. Use of topical lidocaine is recommended to be limited to the management of peripheral neuropathic type pain that has not responded to first-line medications such as antidepressants or anticonvulsants. Based on the clinical documentation provided, there has not been failure of a first-line medication. As such, there does not appear to be a clear indication for the utilization of this topical patch. This request is considered not medically necessary.