

Case Number:	CM14-0011121		
Date Assigned:	02/21/2014	Date of Injury:	03/11/2011
Decision Date:	06/13/2014	UR Denial Date:	12/26/2013
Priority:	Standard	Application Received:	01/27/2014

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 Sports Medicine and is licensed to practice in Texas. 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 52 year old female with an injury reported on 03/11/2011. The mechanism of injury was described as a fall. The clinical note dated 02/11/2014, reported that the injured worker complained of low back pain that radiates to the left lower extremity. The physical examination findings reported spinal vertebral tenderness bilaterally in the lumbar spine at the L4-S1 levels with right greater than left. The injured worker's diagnoses included left knee arthroscopy, lumbar radiculitis, right hand pain, bilateral knee pain, right knee internal derangement and lap band in 2004. The request for authorization date was not provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

PRILOSEC 20 MG, # 30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms & Cardiovascular Risk..

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms & Cardiovascular Risk, Page(s): 68.

Decision rationale: The injured worker complained of low back pain that radiates to the left lower extremity. The CA MTUS guidelines recommend the use of proton pump inhibitors if there is a history of gastrointestinal bleeding or perforations, a prescribed high dose of NSAIDs

and a history of peptic ulcers. Within the clinical notes reviewed there was a lack of documentation of any medication the injured worker was taking; hence, it is unable to be determined if any medication would warrant the use of a proton pump inhibitor. The injured worker also fails to fit the criteria of any significant risk for gastrointestinal bleeding or perforation. Therefore, the request for Prilosec is not medically necessary.

TRAMADOL 50 MG, # 30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Specific Drug List, Tramadol, Page(s): 91-93.

Decision rationale: The injured worker complained of low back pain that radiates to the left lower extremity. According to the California MTUS guidelines Tramadol (Ultram) is a centrally acting synthetic opioid analgesic and it is not recommended as a first-line oral analgesic. It was noted that the injured worker complained of low back radicular pain and was rated 10/10; however, it is unclear what medications the injured worker is presently prescribed. It was also unclear if tramadol has been utilized and its efficacy to the injured worker's pain. Therefore, the request for Tramadol is not medically necessary.

VOLTAREN GEL 1 % 1 TUBE: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Voltaren. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Voltaren Gel.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, Page(s): 111-112.

Decision rationale: The injured worker complained of low back pain that radiates to the left lower extremity. It was noted per physical examination findings the injured worker's lumbar region had tenderness per palpation at the L4-S1 levels with right greater than left. The California MTUS guidelines recommend voltaren gel 1% as indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). It has not been evaluated for treatment of the spine, hip or shoulder. It is unclear what medications the injured worker is presently prescribed. It was also unclear if voltaren gel 1% has been utilized and its efficacy to the injured worker's pain. There is a lack of clinical information as to the location of administration the voltaren gel will be prescribed. The injured worker's chief complaint is pain to her low back, and per guidelines voltaren gel is not recommended for treatment of the spine. Therefore, the request for Voltaren Gel is not medically necessary.