

Case Number:	CM14-0014914		
Date Assigned:	02/21/2014	Date of Injury:	05/05/2008
Decision Date:	07/03/2014	UR Denial Date:	01/03/2014
Priority:	Standard	Application Received:	02/06/2014

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 Texas and Ohio. 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 70-year-old male who reported an injury on 05/05/2008. The mechanism of injury was a trip and fall. The patient had previously been treated with physical therapy, epidural steroid injections, an RAF, and medications. The documentation of 12/23/2013 revealed the patient had complaints of low back pain. The patient was 20% better with rest. It was indicated the patient additionally was experiencing abdominal pain and chest pains after medications. The diagnoses included lumbar disc bulge with radiculitis, status failed 6 epidurals, rule out epidural hematoma, and status failed postoperative radiofrequency desensitization, urinary incontinence, sexual dysfunction secondary to complication of failed radiofrequency desensitization and insomnia. The treatment plan included a TENS unit at home, a lumbar brace to use at home, continue physiotherapy 2 times 3, refer to an internist for follow-up on hypertension and urinary incontinence, EMG/NCV of the upper extremities to rule out neurologic causation of left bicipital atrophy, spine consultation, topical Transdermal creams for pain, Omeprazole 20 mg 1 by mouth twice a day and Tramadol 50 mg 1 by mouth twice a day as needed pain #90.

IMR ISSUES, DECISIONS AND RATIONALES

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

OMEPRAZOLE 20MG #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI SYMPTOMS & CARDIOVASCULAR RISK Page(s): 68.

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

Decision rationale: The Chronic Pain Medical Treatment Guidelines recommend proton pump inhibitors for injured workers at risk for gastrointestinal events. The guidelines recommend that clinicians utilize the following criteria to determine if the injured worker is at risk for gastrointestinal events: (1) age 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID's. The medical documentation did not indicate the injured worker had gastrointestinal symptoms. It did not appear the injured worker had a history of peptic ulcer, GI bleed, or perforation; it did not appear the injured worker is at risk for gastrointestinal events. The clinical documentation submitted for review indicated the patient had complaints of pain due to medications. The documentation failed to provide the efficacy of the medication and failed to provide rationale for sixty tablets. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Omeprazole 20 mg #60 is not medically necessary.

TOPICAL TRANSDERMAL CREAM: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL ANALESICS Page(s): 111-113.

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

Decision rationale: The Chronic Pain Medical Treatment Guidelines recommend topical analgesics for neuropathic pain after trials of antidepressants and anticonvulsants have failed. There was a lack of documentation indicating the injured worker had a trial and failure of anticonvulsants and antidepressants. The clinical documentation submitted for review failed to indicate the specific Transdermals that were being requested. The duration of use could not be established through the supplied documentation. The request as submitted failed to indicate the name, frequency, quantity, and strength of medication being requested so that specific guidelines could be applied. Given the above, the request for topical Transdermal cream is not medically necessary.