

Case Number:	CM14-0017793		
Date Assigned:	04/16/2014	Date of Injury:	09/16/1999
Decision Date:	06/03/2014	UR Denial Date:	01/27/2014
Priority:	Standard	Application Received:	02/12/2014

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 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 injured worker is a 55-year-old male who reported an injury on 09/16/1999 secondary to unknown mechanism of injury. The diagnosis is lumbar facet pain improved since radiofrequency. The injured worker was evaluated on 03/04/2014 for reports of low back and left leg pain with increased leg muscle cramps since discontinuing the norflex. The exam noted tender lumbar facet joints, discomfort with lumbar extension and flexion and bilateral myofascial calf tenderness. The plan of care indicated continued medication therapy. There is no evidence of a request for authorization or rationale in the documentation provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

RETROSPECTIVE REQUEST FOR GABAPENTIN 600MG: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Section Antiepilepsy drugs, Page(s): 16-18.

Decision rationale: The California/MTUS Chronic Pain Medical Treatment Guidelines state the use of anti-epilepsy drugs for the use of myofascial pain is not recommended. There is a lack of evidence to demonstrate that they significantly reduce the level of myofascial or other sources of

somatic pain. The injured worker has complaints of neuropathic pain; however, there is a lack of deficits on physical examination. Furthermore, the request does not include the number of tablets requested. Therefore, based on the documentation provided, the request is non-certified.

RETROSPECTIVE REQUEST FOR HYDROCODONE/APAP 10/325 MG: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-79.

Decision rationale: The California/MTUS Chronic Pain Medical Treatment Guidelines state ongoing management of opioid use should include ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. There is no evidence in the documentation provided of pain and functional level assessment, monitoring of appropriate use of the medication and side effects. Furthermore, the request does not include the number of tablets requested. Therefore, based on the documentation provided, the request is non-certified.

RETROSPECTIVE REQUEST FOR MELOXICAM 15MG: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines anti-inflammatory medications..

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Non-steroidal anti-inflammatory drugs (NSAIDs), Page(s): 68.

Decision rationale: The California/MTUS guidelines state the use of non-steroidal anti-inflammatory drugs (NSAIDs) is recommended as an option for low back pain for short term symptomatic relief. The documentation provided indicates the injured worker has been prescribed meloxicam since at least 07/16/2013. This is time exceeds the duration for short-term use. Furthermore, the request does not include the number of tablets requested. Based on the documentation provided, the request is non-certified.

RETROSPECTIVE REQUEST FOR OMEPRAZOLE 20MG: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES; PROTON PUMP INHIBITORS.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Non-steroidal anti-inflammatory drugs (NSAIDs), Page(s): 68.

Decision rationale: The California/MTUS Chronic Pain Medical Treatment Guidelines state proton pump inhibitors are recommended for patients with risk of gastrointestinal events; however, the injured worker has been non-certified for prescribed non-steroidal anti-

inflammatory drugs (NSAIDs) and there is no evidence of risk factors for a gastrointestinal event in the documentation provided. Furthermore, the request does not include the number of tablets requested. Based on the documentation provided, the request is non-certified.

RETROSPECTIVE REQUEST FOR ORPHENADRINE 100MG: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antispasmodics, Page(s): 64-65.

Decision rationale: The California/MTUS Chronic Pain Medical Treatment Guidelines state the use of antispasmodics is often used to decrease muscle spasms in patients with low back pain; however, the documentation provided indicates the injured worker has been discontinued from this medication. Furthermore, the request does not include the number of tablets requested. Therefore, the request is non-certified.