

Case Number:	CM14-0127291		
Date Assigned:	08/15/2014	Date of Injury:	04/26/2012
Decision Date:	09/15/2014	UR Denial Date:	07/28/2014
Priority:	Standard	Application Received:	08/11/2014

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 and is licensed to practice in Nevada. 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 56-year-old individual was reportedly injured on April 26, 2012. The mechanism of injury was not listed in these records reviewed. The most recent progress note, dated June 25, 2014, indicated that there were ongoing complaints of neck pain described as sharp and radiating into the bilateral upper extremities, migraine headaches, and constant low back pain with migration into the bilateral lower extremities. The physical examination demonstrated 6 foot, 239 pound individual who is normotensive. There was tenderness to palpation of the cervical spine, a decrease in range of motion, no evidence of instability and normal sensation strength. The lumbar spine was noted muscle tenderness and spasm, seated nerve root test to be positive, a decrease in lumbar flexion extension, and no evidence of instability with a normal sensory and strength assessment. Diagnostic imaging studies were not reported. Previous treatment included medications, physical therapy and other conservative pain management interventions. A request had been made for multiple medications and was not certified in the pre-authorization process on July 28, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Diclofenac ER 100mg #120 1/day as needed: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111 of 127.

Decision rationale: This is a non-steroidal medication that is not recommended for the first-line use secondary to the increased side effect risk profile. Significant cardiovascular events occurred during trials. As outlined in the MTUS, this medication is recommended to be avoided. Furthermore, when noting the level of pain complaints, the current physical examination reported, and the lack of any improvement, there is no clinical indication that there is any efficacy or utility with the use of this medication. Therefore, when combining the lack of improvement with the increased side effect risk profile, there is little data presented to support the medical necessity of this preparation.

Omeprazole 20mg #120 1 12H PRN: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68 of 127.

Decision rationale: As noted in the MTUS, this proton pump inhibitor is useful for the treatment of gastroesophageal reflux disease. It can also be used as a protectorant against unspecified gastrointestinal disorders associated with non-steroidal medications. The records do not indicate that there are any gastric complaints, findings on physical examination relative to gastritis or other gastroesophageal changes, and accordingly, there is no medical necessity for the continued use of this medication.

Ondansetron 8mg ODT #30 PRN no more than 2/day: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Per Medscape, Ondansetron.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Pain chapter updated August 2014.

Decision rationale: It is noted that this medication is not addressed in the MTUS or ACOEM guidelines. The parameters outlined in the ODG are applied. This medication is indicated for nausea and/or vomiting secondary to chemotherapy, radiation and postoperative period. There are no noted complaints of nausea and vomiting identified in the progress notes presented for review. No surgical indication is presented. As such, the clinical indication for the medical necessity of this medication has not been established.

Tramadol ER #90 1/day as needed: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol (Ultram; Ultram ER; generic available in immediate release tablet).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 82,113 of 127.

Decision rationale: The California MTUS guidelines support the use of tramadol (Ultram) for short-term use, after there has been evidence of failure of a first-line option, evidence of moderate to severe pain, and documentation of improvement in function with the medication. A review, of the available medical records, fails to document any improvement in function or pain level with the previous use of tramadol. As such, the request is not considered medically necessary.

Menthoderm gel #120 up to QID: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 105 of 127.

Decision rationale: Menthoderm gel is a topical analgesic with the active ingredient methyl salicylate and menthol. MTUS treatment guidelines support methyl salicylate over placebo in chronic pain; however, there is no evidence-based recommendation or support for menthol. MTUS guidelines state that topical analgesics are "largely experimental," and that "any compound product, that contains at least one drug (or drug class), that is not recommended, is not recommended". Menthoderm is not classified as an anti-inflammatory drug, muscle relaxant or neuropathic agent. As such, this request is not considered medically necessary.