

Case Number:	CM14-0127519		
Date Assigned:	08/15/2014	Date of Injury:	10/17/2008
Decision Date:	09/15/2014	UR Denial Date:	07/31/2014
Priority:	Standard	Application Received:	08/12/2014

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 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 58-year-old individual was reportedly injured on October 17, 2008. The mechanism of injury was not listed in these records reviewed. The Agreed Medical Examination, dated April 14, 2014, indicated that there were ongoing complaints of depression, anxiety, and low back pain. The physical examination demonstrated a 5'7", 334 (also reported as 370) pound individual who is noted to be hypertensive, diabetic, with obstructive small airway disease. Diagnostic imaging studies objectified degenerative changes. The progress note, dated May 12, 2014, noted "no real improvement," a relatively stable weight, and no positive effects of the medication protocols. Previous treatment included 7 hours of psychological testing (noting a depression and anxiety disorder). A request had been made for multiple medications and was not certified in the pre-authorization process on July 31, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

TRAMADOL ER 150 MG, 1 CAPS PO TWICE A DAY: Upheld

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

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

Decision rationale: As noted in the MTUS, this medication is a centrally acting synthetic opioid analgesic. This is not recommended as a first-line therapy. The progress notes, presented, did not outline what other medications have been employed to address the chronic pain complaints. It was also noted that this individual has had multiple previous industrial injuries. The success of previous pain management interventions have not been noted. There is no indication that this medication is having any efficacy in terms of dealing with the pain complaints. As such, based on the limited clinical information presented, there is insufficient data to establish the medical necessity for the ongoing use of this medication.

NIZATIDINE 150 MG, 1 CAPS TWICE PER DAY: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI SYMPTOMS AND CARDIOVASCULAR RISKS.

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

Decision rationale: This medication is an over-the-counter H2 receptor antagonist designed to address the complaints associated with gastritis. The medical records indicate there are complaints of gastritis that are resolved with this medication. There is a clear clinical indication as the complaints are present, and there is a positive response. Therefore, this is medically necessary.

OMEPRAZOLE 20 MG, 1 CAP PO DAILY: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI SYMPTOMS AND CARDIOVASCULAR RISKS.

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

Decision rationale: This medication is useful in the treatment of gastroesophageal reflux disease. It is also noted this individual is able to use over-the-counter preparations to address these gastric complaints. Therefore, the medical necessity of this medication has not been established.

XOLIDO 2 % CREAM APPLY TO AFFECTED AREA AS DIRECTED: 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): 56-57, 112.

Decision rationale: MTUS guidelines support the use of topical lidocaine for individuals with neuropathic pain that have failed treatment with first-line therapy including antidepressants or

anti-epileptic medications. Based on the clinical documentation provided, the claimant has no objectified neuropathic pain generators that are amenable to such intervention. Furthermore, there is no clinical indication presented that this medication has demonstrated any efficacy or utility. As such, the request is considered not medically necessary.