MAXIMUS Federal Services

Case Number:	CM14-0134014		
Date Assigned:	08/25/2014	Date of Injury:	09/25/2013
Decision Date:	10/02/2014	UR Denial Date:	07/30/2014
Priority:	Standard	Application Received:	08/18/2014

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 60 year-old individual was reportedly injured on September 25, 2013. The mechanism of injury is noted as a repetitive motion type event. The most recent progress note, dated June 18, 2014 indicates that there are ongoing complaints of neck pain, constant low back pain, and bilateral knee pain. The physical examination demonstrated a 5'11", 210 pound individual who is normotensive (116/74) and in no acute distress. The cervical spine was tender to palpation with some muscle spasm noted. A decrease in range of motion is reported. No specific motor function of sensory function losses identified however more some sensory changes noted subjectively. There is pain and tenderness in the lower lumbar musculature and a decrease in lumbar spine range of motion. Deep tendon reflexes are intact, and no sensory losses identified. Diagnostic imaging studies objectified ordinary disease of life degenerative changes in both the cervical spine and lumbar spine. Previous treatment includes multiple medications and physical therapy. A request had been made for multiple medications and was not certified in the pre-authorization process on July 30, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Diclofenac Sodium ER (Voltaren SR) 100 MG #120: Upheld

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

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

Decision rationale: As outlined in the MTUS, this is a nonselective non-steroidal anti-inflammatory medication that is not recommended for first-line use secondary to the increased risk profile. It is reported there are some risks to the cardiovascular system similar to the medication Vioxx which even taken off the market. The records presented for review do not indicate any prior course of non-steroidal anti-inflammatory medications that have been employed. Therefore, when noting no efficacy or utility with medication, or what prior nonsteroidals have been used taking into account the parameters noted in the MTUS this is not medically necessary.

Omeprazole 20 mg #120: Upheld

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

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

Decision rationale: When noting the date of injury, the reported mechanism of injury, and the lack of specific complaints relative to the gastrointestinal tract there is no clear clinical indication for the medical necessity of this preparation. This is a protein pump inhibitor indicated for the treatment of gastroesophageal reflux disease. There are no complaints of gastritis, guess intestinal distress, or any other physical examination parameter that would support the use of gastric protectant type medication. Therefore, based on the clinical information presented for review taking into account the parameters noted in the MTUS, this is not medically necessary.

Ondansetron ODT Tablets 8 mg #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG (Official Disability Guidelines)Pain

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 September, 2014

Decision rationale: This medication is not covered in the MTUS or the ACOEM guidelines. The parameters noted in the ODG are used. The progress notes I have do not reflect any subjective complaints of nausea or vomiting nor is there a postoperative situation. As such, no clinical indication presented that would require this medication. This is not medically necessary.

Orphenadrine Citrate ER 100mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain).

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

Decision rationale: This medication is a family of antihistamines. This is used to treat painful muscle spasms and Parkinson's disease. While noting there is evidence of muscle spasm on physical examination there is no indication that this medication has demonstrated any efficacy or utility in terms of a ameliorating the symptomology. There is no increase functionality. As such, there is no clear continued indicated supporting the continued use of this medication. Therefore, this request is not medically necessary.

Tramadol ER 150MG #90: Upheld

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

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

Decision rationale: This medication is a synthetic opioid analgesic useful in the treatment of breakthrough pain. As noted in the MTUS, this is not recommended as a first-line therapy. Furthermore, there is to be objective occasion of increased functionality or decrease pain to support his continued use. Seeing none, there is insufficient clinical evidence presented to support the medical necessity of this medication. Therefore, this request is not medically necessary.

Sumatriptan Succinate Tablets 35mg #9 x2: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG (Official Disability Guidelines)Head

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

Decision rationale: This medication is indicated for the treatment of migraine headaches. However, when noting the specific definition of migraine headache tempered by the lack of specific complaints noted in the progress notes there is insufficient clinical data presented to support the medical necessity of the continued use of this medication. Therefore, this request is not medically necessary.