

Case Number:	CM14-0137432		
Date Assigned:	09/05/2014	Date of Injury:	08/22/2013
Decision Date:	10/02/2014	UR Denial Date:	08/14/2014
Priority:	Standard	Application Received:	08/25/2014

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 Interventional Spine 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 patient is a 54-year-old female with date of injury of 08/22/2013. The listed diagnoses per [REDACTED] dated 05/13/2014 are: 1. Lumbar radiculopathy. 2. Anxiety state, NOS. 3. Gastroduodenal disorders, NOS. According to the progress report dated 04/16/2014, the patient reports no significant improvement since the last exam. The patient has persistent pain in her lower back that radiates to her right lower extremity. She has pain and difficulty with sitting, lying, and walking. She also reports neck pain and right shoulder pain. The physical examination shows paravertebral muscle tenderness in the lumbar spine. Spasm is present. Range of motion is decreased by 30%. Straight leg raise test is positive bilaterally. Sensation is reduced in the bilateral L5 dermatomal distribution. The utilization review denied the request on 05/30/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Omeprazole DR 20mg #30 2 refills: Overturned

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68-69.

Decision rationale: This patient presents with lower back pain radiating to the right lower extremity. The treating physician is requesting Omeprazole DR 20 mg. The MTUS Guidelines page 68 and 69 on NSAIDs, GI symptoms, and cardiovascular risks states that it is recommended with precaution for patients at risk for gastrointestinal events: Ages greater than 65; History of peptic ulcer; GI bleed or perforation; Concurrent use of ASA or corticosteroids and/or anticoagulants; High-dose multiple NSAIDs. The patient was prescribed omeprazole on 01/21/2014. The treating physician does document a diagnosis of gastroduodenal disorder and the requested Omeprazole is reasonable. The request is medically necessary.

Carlsoprodol 350gm #60 2 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol (Soma) Page(s): 29.

Decision rationale: This patient presents with lower back pain radiating to the right lower extremity. The treating physician is requesting Carisoprodol 350 mg quantity #60 with 2 refills. The MTUS Guidelines page 21 on Carisoprodol (Soma) states that it is not recommended. This medication is not indicated for long-term use. Carisoprodol is a commonly prescribed centrally acting skeletal muscle relaxant whose primary active metabolite is meprobamate (a Schedule IV controlled substance). The patient was prescribed Carisoprodol on 02/18/2014 and MTUS does not support the long-term use of this medication. The request is not medically necessary.

Voltaren 1%gel: Upheld

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

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

Decision rationale: This patient presents with lower back pain radiating to the right lower extremity. The treating physician is requesting Voltaren 1% gel. The MTUS Guidelines page 111 on topical analgesics states that it is primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Furthermore, Voltaren gel 1% (diclofenac) is indicated for relief of osteoarthritis, pain in joints that lend themselves to topical treatments such as the ankle, elbow, foot, hand, knee, and wrist. It is not recommended for the treatment of the spine, hip, or shoulder. This patient does not have a diagnosis of osteoarthritis. Furthermore, it appears that the patient is using Voltaren gel for low back pain which this medication is not indicated for. The request is not medically necessary.