

Case Number:	CM14-0041341		
Date Assigned:	08/01/2014	Date of Injury:	08/16/2004
Decision Date:	09/30/2014	UR Denial Date:	03/05/2014
Priority:	Standard	Application Received:	03/12/2014

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 Orthopedic Surgery and is licensed to practice in Mississippi. 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 41 year-old male was reportedly injured on August 16, 2004. The mechanism of injury is not listed in the records reviewed. The most recent progress note, dated July 11, 2014 indicates that there are ongoing complaints of low back pain and right knee pain. The physical examination demonstrated pain over the sacroiliac joints, a positive FABER, a decrease in sensory evaluation in the bilateral lower extremities and a positive McMurray's in the right knee. Diagnostic imaging studies were not presented for review. Previous treatment includes right knee surgery, enhanced imaging studies, lumbar fusion surgery, multiple medications and rehabilitation protocols. A request had been made for multiple medications and was not certified in the pre-authorization process on March 5, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Naproxen 550mg, #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Osteoarthritis (including knee and hip) Page(s): 67, 69, 72, 78.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS; (Effective July 18, 2009 Page(s): 73OF 127.

Decision rationale: As outlined in the MTUS, this medication is indicated for relief relative to the signs and symptoms of osteoarthritis. However, there is no noted osteoarthritis reported in the progress notes reviewed. Furthermore, there is no clinical indication that this medication has having any efficacy or utility in terms of reducing the symptomology or increasing functionality. Therefore, based on this lack of responses medication there is no clear clinical indication of the medical necessity for this preparation. The request is not medically necessary.

Flurbiprofen 300mg (quantity unspecified): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Osteoarthritis (including knee and hip) Page(s): 67, 69, 72, 78.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines C.R. 9792.20 - 9792.26. MTUS (Effective July 18, 2009) Page(s): 72 OF 127.

Decision rationale: This is a non-steroidal anti-inflammatory medication indicated for the treatment of osteoarthritis. It is noted that a separate non-steroidal had been employed. The progress notes do not reflect that there has been any improvement or amelioration of symptomology associated with the use of these medications. According, there is no clear clinical indication presented for the continued use of these medications or the medical necessity thereof. The request is not medically necessary.

Ultram ER 150mg, #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Osteoarthritis (including knee and hip) Page(s): 67, 69, 72, 78.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26; MTUS (Effective July 18, 2009 Page(s): Page 82, 113 of 127..

Decision rationale: As outlined in the MTUS, this is a synthetic opioid analgesic not recommended as a first-line oral analgesic. Furthermore, there is no clinical indication from the progress notes reviewed that there has been any amelioration and the pain complaints. Therefore, there is no data to suggest that this medication is demonstrating any efficacy or utility. As such, this is not medically necessary.

Prilosec 20mg, #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Osteoarthritis (including knee and hip) Page(s): 67, 69, 72, 78.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 68 of 127.

Decision rationale: This is a protein pump inhibitor useful for the treatment of gastroesophageal reflux disease and is considered a gastric protectorate for those individuals

utilizing non-steroidal medications. When noting the date of injury, the injury sustained, and the current clinical assessment is interesting to note there are no complaints relative to the gastrointestinal tract. Furthermore, there are no physical examination findings indicating a gastritis, gastrointestinal disturbance or reflux disease. Therefore, based on the clinical information presented for review tempered by the parameters outlined in the MTUS and noting that there is no functional need or improvement in the progress notes the medical necessity has not been established. As such, this is not medically necessary.

Fexmid 75mg, #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Osteoarthritis (including knee and hip) Page(s): 67, 69, 72, 78.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 41, 64 OF 127.

Decision rationale: This medication is a cyclobenzaprine which is recommended for a short course of therapy alone. There is no recommendation for chronic, indefinite routine use. Furthermore, the physical examination does not demonstrate any increase in the functionality of the injured employee as a result of using this medication. As such, there is no medical necessity established for the continued use of this preparation. The request is not medically necessary.

Doral 15mg, #60: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, 11th edition (web), 2013, Pain Chapter, Doral (Insomnia Treatment).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 -9792.26; MTUS (Effective July 18, 2009) Page(s): 24 OF 127.

Decision rationale: This medication is a benzodiazepine sleep hypnotic. While noting that appropriate sleep hygiene is crucial in treating chronic pain, the use of this medication is indicated for short-term applications only. There is no indication for long-term, daily or indefinite use as are issues relative to dependence and addiction. Furthermore, there are no long-term studies supporting the use of this medication. As such, the medical necessity has not been established to continue this medication. The request is not medically necessary.