

Case Number:	CM14-0045916		
Date Assigned:	07/02/2014	Date of Injury:	12/03/2008
Decision Date:	08/27/2014	UR Denial Date:	04/03/2014
Priority:	Standard	Application Received:	04/14/2014

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 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 injured worker is a 47-year-old male who reported an injury on 12/03/2008 due to a slip and fall. The injured worker sustained an injury to his low back. The injured worker's treatment history included a lumbar support, physical therapy, a home exercise program, multiple medications, and psychiatric support. The most recent clinical examination submitted for review was dated 12/12/2013 and this was a Qualified Medical Examination pertaining to the injured worker's hearing. No specific information regarding medication usage was provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

Anaprox DS 550 mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-73.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic pain and NSAIDs (non-steroidal anti-inflammatory drugs), page(s) 60 and 67 Page(s): 60 AND 67.

Decision rationale: The MTUS Chronic Pain Guidelines does recommend nonsteroidal anti-inflammatory medications as a first line medication in the management of chronic pain. However, the MTUS Chronic Pain Guidelines recommends the use of medications in the

management of chronic pain be supported by documented functional benefit, evidence of pain relief, and functional benefit. There was no recent clinical documentation to support that the injured worker has deficits that require medication management. Additionally, there was no documentation of recent treatment history to support the need for medications. Therefore, continued use of Anaprox is not supported. Furthermore, the request as it is submitted does not clearly identify a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. The request is not medically necessary and appropriate.

Cyclobenzaprine 7.5 mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 41, 64.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants, page(s) 63 Page(s): 63.

Decision rationale: The MTUS Chronic Pain Guidelines recommends muscle relaxants for short durations of treatment, not to exceed 2 to 3 weeks for acute exacerbations of chronic pain. The clinical documentation submitted for review did not provide any recent evidence of an acute exacerbation that would benefit from the use of Cyclobenzaprine. There was no recent treatment history provided to determine the appropriateness of this medication. Furthermore, the request as it is submitted does not clearly identify a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the request is not medically necessary or appropriate.

Dyotin SR 250 mg #60 caps: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines AEDs Page(s): 16-22.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Epileptics, page(s) 16 Page(s): 16.

Decision rationale: The MTUS Chronic Pain Guidelines does recommend the use of anticonvulsants as a first line medication in the management of chronic pain. However, the clinical documentation submitted for review did not provide any recent assessment to support the need for medication management. There was no recent treatment history to determine the appropriateness of this medication. Furthermore, the request as it is submitted does not clearly identify a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Dyotin SR 250 mg #60 capsules are not medically necessary or appropriate.

Omeprazole 20 mg #60: Upheld

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

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

Decision rationale: The MTUS Chronic Pain Guidelines recommends gastrointestinal protectants for injured workers at risk for developing gastrointestinal disturbances related to medication usage. The clinical documentation submitted for review does not provide a recent assessment of the injured worker's gastrointestinal system to support that they are at continued risk for developing disturbances related to medication usage. Furthermore, the request as it is submitted does not clearly identify a frequency of treatment. In the absence of this information, the appropriateness of the request cannot be determined. As such, the requested Omeprazole 20 mg #60 is not medically necessary or appropriate.

Theraflex cream 180 mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines topical medications Page(s): 111-113.

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

Decision rationale: The MTUS Chronic Pain Guidelines does not support the use of topical analgesics except in specific instances. The requested medication is a non-FDA approved topical cream containing amino acids, minerals, and botanicals. Additionally, the clinical documentation submitted for review does not provide a recent assessment of pain or treatment history for the injured worker that would provide justification for medication management. Furthermore, the request as it is submitted does not have a frequency of treatment or applicable body part. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Theraflex cream 180 mg is not medically necessary or appropriate.

Keratek gell 4 oz. bottle: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines topical analgesics Page(s): 111-113.

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

Decision rationale: The MTUS Chronic Pain Guidelines does not support the use of topical analgesics except in specific instances. The requested medication is a non-FDA approved topical cream containing amino acids, minerals, and botanicals. Additionally, the clinical documentation submitted for review does not provide a recent assessment of pain or treatment history for the injured worker that would provide justification for medication management.

Furthermore, the request as it is submitted does not have a frequency of treatment or applicable body part. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the request is not medically necessary and appropriate.