

Case Number:	CM14-0048831		
Date Assigned:	07/07/2014	Date of Injury:	08/10/2004
Decision Date:	09/15/2014	UR Denial Date:	03/06/2014
Priority:	Standard	Application Received:	03/27/2014

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 injured worker is a 55-year-old male who was reportedly injured on August 10, 2004. The mechanism of injury was not listed in these records reviewed. The most recent progress note, dated February 25, 2014, indicated that there were ongoing complaints of low back pain. The physical examination demonstrated well-developed, well-nourished individual in no acute distress. Lumbar spine range of motion was slightly reduced. There was tenderness to palpation of the lumbar spine, and straight leg raising was positive. Deep tendon reflexes were intact and equal bilaterally. Diagnostic imaging studies were not reviewed. Previous treatment included conservative care, multiple medications and physical therapy. A request was made for multiple medications and was not certified in the pre-authorization process on March 6, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco tablets 10/325mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use Page(s): 88,89,93.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-78.

Decision rationale: When noting the date of injury, the injury sustained, the current clinical condition outlined and the physical examination findings, there was no clear clinical indication presented of any moderate to severe breakthrough pain. As such, as noted in the California Medical Treatment Utilization Schedule, this medication would not be clinically indicated. This is not designed to be a chronic, indefinite and routine use of opioid. Therefore, based on the clinical information presented for review and by the parameters outlined in the California Medical Treatment Utilization Schedule, the medical necessity has not been established.

Soma tablets 350mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol (Soma, Soprodol 350, Vanadom, generic available) Page(s): 65.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol Page(s): 29 of 127.

Decision rationale: The California Medical Treatment Utilization Schedule specifically recommends against the use of Soma and indicates that it is not recommended for long-term use. Based on the clinical documentation provided, the clinician did not provide rationale for deviation from the guidelines. As such, with the very specific recommendation of the California Medical Treatment Utilization Schedule against the use of this medication, this medication is not medically necessary.

Prilosec delayed release capsules 20mg #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68 of 127.

Decision rationale: This medication is a proton pump inhibitor designed for the treatment of gastroesophageal reflux disease. It is also considered a possible protectant for individuals utilizing non-steroidal medications. There were no complaints relative to the gastrointestinal system that would warrant a use of this medication. There was no finding on physical examination to see if the need for this medication is indicated. Therefore, based on the limited clinical fracture presented for review, there is no medical necessity established for this preparation.

Comprehensive metabolic panel: Upheld

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 Page(s): 86-93.

Decision rationale: When noting the progress notes reviewed, with the specific absence of any complaints or symptoms, and taking into account the medication profile outlined, there was no clinical indication presented for a periodic assessment of laboratory studies. There was no noted non-steroidal medication being used. As such, the medical necessity for this assessment has not been established.