

| | | | |
|-----------------------|--------------|------------------------------|------------|
| Case Number: | CM14-0054304 | | |
| Date Assigned: | 07/09/2014 | Date of Injury: | 07/26/2010 |
| Decision Date: | 08/29/2014 | UR Denial Date: | 03/25/2014 |
| Priority: | Standard | Application Received: | 04/23/2014 |

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 Pain Management & Rehabilitation and is licensed to practice in Texas. 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 60 year old male who had a work related injury of 07/26/10. The mechanism of injury is undisclosed. Most recent progress note submitted for review was dated 06/20/13. The injured worker presented for initial visit complaining of low back pain radiating to the buttocks and right knee. Predominate complaint was low back pain. He had minimal improvement despite antiinflammatories and physical therapy. Patient described 8/10. The injured worker denied having any surgeries for his low back. Physical examination demonstrated: lumbar spine tenderness to palpation over paraspinal musculature, normal lordosis, flexion 60 degrees extension 25 degrees, bilateral lateral bending 25 degrees, no tenderness to palpation over spinous processes, full range of motion bilateral lower extremities, strength 5/5 in lower extremities, sensation diminished over S1 dermatome, 2+ reflexes in patella and achilles, negative Achilles clonus and straight leg raises (SLRs). Diagnostic imaging studies consists of MRI report is not available for review of L4 through S1 stenosis. Diagnoses include L4 through S1 stenosis, and refractory to conservative treatment. Plan since patient failed conservative treatment with antiinflammatories physical therapy, and symptoms are concordant with MRI findings the provider was recommended L4 through S1 decompression with possible fusion. There was no clinical documentation in all of the medical records reviewed that the injured worker had gastrointestinal problems or at risk for gastrointestinal problems. He also had no findings of neuropathic pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective request for Omeprazole 20mg #30, DOS 03/12/14: Upheld

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

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, <I Proton pump inhibitors (PPIs).

Decision rationale: Medical necessity has not been established. The clinical documentation submitted for review does not support the request for Gabapentin. There is no clinical evidence submitted that the injured worker has neuropathic symptoms. The request for retrospective request for Gabapentin 300 milligrams quantity 60, date of service 03/12/14, is not medically necessary.

Retrospective request for Gabapentin 300mg #60, DOS 03/12/14: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Specific Anti-Epilepsy Drugs Page(s): 18-19.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AED) Page(s): 16-22. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain chapter, Antiepilepsy drugs (AED).

Decision rationale: The request for retrospective request for Omeprazole 20 milligrams quantity of 30, date of service 03/12/14, is not medically necessary. The clinical documentation submitted for review does not support the request. There was no clinical documentation in all of the medical records reviewed that the injured worker had gastrointestinal problems or at risk for gastrointestinal problems. As such, medical necessity has not been established. The request is not medically necessary.