

Case Number:	CM14-0057627		
Date Assigned:	07/09/2014	Date of Injury:	05/16/2007
Decision Date:	09/05/2014	UR Denial Date:	04/01/2014
Priority:	Standard	Application Received:	04/28/2014

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 records, presented for review, indicate that this 51 year old female was reportedly injured on May 16, 2007. The mechanism of injury was noted as while descending a ladder, an injury to the right ankle occurred. The most recent progress note, dated April 14, 2014, indicated that there were ongoing complaints of ankle pain, hypertension, right knee injury and low back pain. The physical examination demonstrated a borderline hypertensive (123/90) female who is 5'4", 230 pounds. The injured worker was noted taking multiple medications to control her blood pressure. No specific findings were noted on physical examination. Diagnostic imaging studies were not presented for review. Previous treatment included orthopedic care for the ankle, knees, low back and internal medicine interventions for hypertension. A request was made for multiple medications and was not certified in the preauthorization process on April 1, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Percocet 10/325 #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 81.

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): 74-78, 88, 91 of 127.

Decision rationale: The records presented for review indicate that the orthopedic surgeon has discharged the individual from his care. The current progress notes do not outline any specific pathology or clinical pain generator to warrant this medication. Therefore, as outlined in the Medical Treatment Utilization Schedule (MTUS), this medication is for severe breakthrough pain. Without the benefit of objectification of a specific pain generator or that there is any objectification that this medication is ameliorating the symptomatology. Based on the progress notes presented for review, this request is considered not medically necessary.

Gabapentin 600mg #90: Upheld

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

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): 16-20, 49 of 127.

Decision rationale: Based on the progress notes presented for review, there was an achilles injury, complaints of low back pain and the current medical records did not identify or objectify any neuropathic lesion. As outlined in the Medical Treatment Utilization Schedule (MTUS), this medication is indicated for a painful diabetic neuropathy or a postherpetic neuralgia. Neither malady exists. Therefore, based on the limited clinical rationale presented for review, there is insufficient information presented to establish the medical necessity of medication. The request is not medically necessary.

Ambien 10mg #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines ,Pain chapter.

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, updated July 2014.

Decision rationale: As outlined in the ODG, this medication is indicated for the short term (four to six weeks) alone. While noting that this is a nonbenzodiazepine hypnotic, the literature does not support indefinite or chronic use of this preparation. Therefore, based on the limited clinical information presented for review, and noting that there is no narrative relative to the sleep hygiene of this individual, there is insufficient medical evidence presented to support the medical necessity of this preparation. The request is not medically necessary.

Soma 350 mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxant Page(s): 63.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines : 8 C.C.R. 9792.20 - 9792.26. MTUS (Effective July 18, 2009) Carisoprodol Page(s): 29.

Decision rationale: As noted in the Medical Treatment Utilization Schedule (MTUS), this medication is not recommended. It is noted that the active metabolite is meprobamate a Schedule five controlled substance. There is no significant efficacy noted in the chronic or long term use of this medication. Therefore, there are specific recommendations against this medication. As such, the request is not medically necessary.

Omeprazole Patch #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines ,Pain ,proton pump inhibitor.

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.

Decision rationale: This medication is a proton pump inhibitor useful in the treatment of gastroesophageal reflux disease or can be considered a gastric protectant for individuals utilizing nonsteroidal medications. However, the transdermal application has not been endorsed in the literature, nor is there any indication of gastric distress, gastroesophageal disease, or other clinical indication of a need for this medication. Therefore, this request is not medically necessary.