

Case Number:	CM14-0073599		
Date Assigned:	07/18/2014	Date of Injury:	02/03/2011
Decision Date:	11/26/2014	UR Denial Date:	05/14/2014
Priority:	Standard	Application Received:	05/20/2014

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 Occupational Medicine 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:

Patient is a 72 year-old female with date of injury 02/03/2011. The medical document associated with the request for authorization, a primary treating physician's progress report, dated 04/24/2014, lists subjective complaints as low back pain. Objective findings: Examination of the lumbar spine revealed tenderness to palpation of the paravertebral muscles with spasm. Range of motion was restricted. Sensation was reduced in the bilateral feet. Straight leg raising test was positive bilaterally. Motor strength was reduced in bilateral ankle/plantar dorsiflexion. Diagnosis: 1. Lumbar radiculopathy 2. Severe spinal stenosis. The medical records supplied for review document that the patient has been taking the following medications for at least as far back as 12/05/2013. Medications: 1. Omeprazole Dr 20mg, #30 SIG: once a day 2. Ketoprofen 75mg, #30 SIG: once a day 3. Orphenadrine Extended Release (ER) 100mg, #60 SIG: one tablet PO BID 4. Medrox pain relief ointment SIG: BID 5. Voltaren 1% Gel SIG: BID.

IMR ISSUES, DECISIONS AND RATIONALES

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

Omeprazole Dr (delayed release) 20mg #30 2refills: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 - 9792.26.

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines, prior to starting the patient on a proton pump inhibitor, physicians are asked to evaluate the patient and to determine if the patient is at risk for gastrointestinal events. Criteria used are: (1) age greater than 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID. There is documentation that the patient has at least one of the risk factors needed to recommend a proton pump inhibitor. The patient is over 65 years old. I am reversing the previous utilization review decision Omeprazole Dr (delayed release) 20mg #30 2 refills is medically necessary.

Ketoprofen 75mg capsule #30 2 refills: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 - 9792.26 Page(s): 67-73.

Decision rationale: The MTUS recommends NSAIDs at the lowest dose for the shortest period in patients with moderate to severe pain. NSAIDs appear to be superior to acetaminophen, particularly for patients with moderate to severe pain. The patient's clinical picture fits the MTUS recommendations for NSAIDs and ketoprofen is a recommended option. I am reversing the previous utilization review decision. Ketoprofen 75mg capsule #30 2 refills is medically necessary.

Orphenadrine Er 100mg #60 2 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 - 9792.26.

Decision rationale: Orphenadrine is an anticholinergic drug of the ethanolamine antihistamine class with prominent central nervous system (CNS) and peripheral actions used to treat painful muscle spasms and other similar conditions, as well as the treatment of some aspects of Parkinson's disease. The MTUS states that muscle relaxants are recommended with caution only on a short-term basis. The patient has been taking Orphenadrine for longer than 2-3 weeks, which is recommended by the MTUS. Orphenadrine Er (extended release) 100mg #60 2 refills is not medically necessary.

Medrox pain relief ointment with 2 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 - 9792.26 Page(s): 28, 112-113.

Decision rationale: Medrox ointment contains a topical analgesic with the active ingredients, Capsaicin 0.0375%, and Menthol USP 5% used for the temporary relief of minor aches and muscle pains associated with arthritis, simple backache, strains, muscle soreness and stiffness. Capsaicin 0.025% topical is recommended only as an option in patients who have not responded or are intolerant to other treatments. According to MTUS there have been no studies of a 0.0375% formulation of Capsaicin and there is no current indication that this increase over 0.025% formulation would provide any further efficacy. Medrox pain relief ointment 2 refills are not medically necessary.

Voltaren 1% gel: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), Voltaren Gel Diclofenac

Decision rationale: According to the Official Disability Guidelines, Voltaren gel is not recommended as a first as a first-line treatment, and is recommended only for osteoarthritis after failure of oral NSAIDs, or contraindications to oral NSAIDs, or for patients who cannot swallow solid oral dosage forms, and after considering the increased risk profile with Diclofenac, including topical formulations. Documentation in the medical record does not meet guideline criteria. Voltaren 1% gel is not medically necessary.