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| Case Number: | CM14-0074273 | | |
| Date Assigned: | 07/16/2014 | Date of Injury: | 03/13/2007 |
| Decision Date: | 09/19/2014 | UR Denial Date: | 05/14/2014 |
| Priority: | Standard | Application Received: | 05/21/2014 |

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 & 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 30-year-old female who was reportedly injured on March 13, 2007. The mechanism of injury was noted as a slip and fall type event. The most recent progress note dated July 2, 2014, indicated that there were ongoing complaints of neck pain, wrist pain, back pain and lower extremity numbness. The physical examination demonstrated a hypertensive (120/90) individual who was reportedly in no acute distress. There was a limited range of motion of the cervical spine, tenderness to palpation, and a limitation of the lumbar spine range of motion. Straight leg raising was positive at 70 bilaterally. Sensation was intact to pinprick in the bilateral upper extremities. Deep tendon reflexes were 2+ equivocal bilaterally and a slight decrease in the C6 distribution was noted. Diagnostic imaging studies objectified multiple level ordinary disease of life degenerative changes. Previous treatment included multiple medications, physical therapy, conservative therapies and interventional spine procedure, such as epidural, and a functional restoration program has been completed. A request was made for multiple medications and was not certified in the pre-authorization process on May 14, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Omeprazole 20mg BID QTY: 30.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI symptoms & cardiovascular risk.

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

Decision rationale: As outlined in the California Medical Treatment Utilization Schedule, this is a proton pump inhibitor useful for the treatment of gastroesophageal reflux disease. It is also indicated as a protectorant for individuals utilizing non-steroidal anti-inflammatory medications. However, it is noted that this individual has been taking medications for a number of years, and there are no complaints of any gastric distress. As such, there is no noted indication or efficacy of this medication. As such, this is not medically necessary.

Melatonin 5mg QTY: 30.00: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG(The Official Disability Guidelines) Head See Sleep Aids.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chronic Pain; Clinical Measures; Medications; Vitamins (Electronically Cited).

Decision rationale: The American College of Occupational and Environmental Medicine specifically recommends against the use of dietary supplements in the treatment of chronic pain. These supplements have not been shown to produce any meaningful benefits or improvements in functional outcomes. Based on the documentation provided, there is no evidence based medicine provided or any demonstration of any efficacy or reduction in pain complaints or increased functionality that would justify the medical necessity of these supplements. As such, the requested nutritional supplement is deemed not medically necessary.

Imitrex 25mg QTY: 30.00: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG(The Official Disability Guidelines)TWC 2012 on the Web (www.odgtreatment.com) Triptans.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) had updated June, 2014.

Decision rationale: This medication is indicated for the treatment of migraine headaches. The progress notes presented for review do not indicate that there were any ongoing migraine headaches, and those that had occurred, are not referenced in terms of the efficacy of this medication. Therefore, based on the clinical information and the progress notes presented for review and by the parameters noted in the Official Disability Guidelines, medical necessity of this preparation has not been established. Therefore the request is not medically necessary.

Physical Therapy appointment for instruction on IF unit pad placement QTY: 1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Guidelines Functional Improvement Measures Transcutaneous electrotherapy Page(s): 98-99; 48; 114-121.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98, 99 of 127.

Decision rationale: When noting the date of injury, the injury sustained, and the response to care, there is a complete lack of any indication for an interferential unit. Therefore, there is no medical necessity for physical therapy appointment, to establish the treatment to place the equipment on one's person. The request is not medically necessary.

Flexeril 7.5mg qhs: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 64-66.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 41, 64 of 127.

Decision rationale: California Medical Treatment Utilization Schedule, Guidelines support the use of skeletal muscle relaxants for the short-term treatment of pain but advises against long-term use. Given the injured worker's date of injury and clinical presentation, the guidelines do not support this long term and indefinite request for chronic pain. As such, the request is not medically necessary.