

Case Number:	CM14-0075850		
Date Assigned:	07/16/2014	Date of Injury:	06/09/2007
Decision Date:	09/09/2014	UR Denial Date:	05/05/2014
Priority:	Standard	Application Received:	05/23/2014

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 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 55-year-old individual was reportedly injured on June 9, 2007. The mechanism of injury was noted as a fall. The most recent progress note, dated April 19, 2014, indicated that there were ongoing complaints of low back and right knee pains. The physical examination was not reported. Diagnostic imaging studies were not presented. Previous treatment included multiple medications, physical therapy, lumbar spine surgical intervention, and total knee arthroplasty. A request had been made for multiple medications and was not certified in the pre-authorization process on May 5, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Voltaren Gel 1% 300 gm. # 30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics; Non-steroidal anti-inflammatory drugs (NSAIDs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines (Effective July 18, 2009) Page(s): 111,112.

Decision rationale: MTUS guidelines support the topical diclofenac for the relief of osteoarthritic pain of the ankle, elbow, foot, hand, knee and wrist. It has not been evaluated for treatment of the spine, hip or shoulder. Outside of the treatment of osteoarthritis, there is no other

clinical indication for the use of this topical non-steroidal anti-inflammatory. The claimant suffers from low back pain and has undergone a total knee arthroplasty of the knee. As such, there is no clinical indication presented for this preparation. The medical necessity is not established.

Omeprazole Capsule 20 mg. # 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Non-steroidal anti-inflammatory drugs (NSAIDs)Gastrointestinal symptoms and cardiovascular risks. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Pain Chapter; www.drugs.com; Stiles S, Vega C. Societies Confront GI Risks of Antiplatelets, NSAIDs in consensus Document. HeartWire, WebMD, October, 2008.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines (Effective July 18, 2009) Page(s): 68.

Decision rationale: As outlined in the MTUS, this medication, a proton pump inhibitor, is issued for the treatment of gastroesophageal reflux disease and is considered as a gastric protectant in some individuals utilizing non-steroidal medications. However, a review of the progress notes indicates that there are no complaints of gastritis or gastrointestinal distress that require such medication. Furthermore, the noted non-steroidal is being delivered in a transdermal fashion negating the need for a gastric protectorate. Therefore, based on the limited records presented for review, the medical necessity of this medication has not been established.

Lexapro 10 mg. # 90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines (Effective July 18, 2009) Page(s): 13-16 & 107.

Decision rationale: This medication is an SSRI, used to address the depression. There is noted depression or anxiety secondary to pain and frustration of not being able to be pain free. However, when noting the ongoing complaints of depression, there is no indication that this medication is demonstrating any efficacy or utility in terms of resolving that aspect. Therefore, the continued use of this medication has not been established to be medically necessary.

Hydrocodone/Acetaminophen 5/325 mg. # 90: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment,Chronic Pain Treatment Guidelines Opioids. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Integrated Treatment/Disability Duration Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines (Effective July 18, 2009) Page(s): 74-78, 88, 91.

Decision rationale: This medication is noted in the MTUS as being indicated for the treatment of moderate to moderately severe pain. However, the requirement is that there is to be documentation of the efficacy in terms of pain reduction, increase functionality, return to work, and no noted side effects. The only note presented is that there is an ongoing complaint of pain. Therefore, it is clear that this medication has not demonstrated any efficacy or utility in terms of addressing the specific complaints. As such, the medical necessity has not been established.