

Case Number:	CM14-0077911		
Date Assigned:	07/21/2014	Date of Injury:	07/28/1998
Decision Date:	09/12/2014	UR Denial Date:	05/15/2014
Priority:	Standard	Application Received:	05/27/2014

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 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:

The injured worker is of unknown age, male and reported an injury on 07/28/1998, due to an unknown mechanism. Diagnosis was headache. Treatment has been with many different medications such as Imitrex, Paxil CR, Flexeril, and Ambien. Diagnostic studies were not submitted. Surgical history was not reported. The injured worker had a physical examination on 06/10/2014 with complaints of headache. The injured worker did state the headaches remained stable. There were no objective physical exam findings reported. Medications were Naprosyn 500 one twice a day, Sonata 10 mg at bedtime as needed, Prevacid 30 mg 1 a day, indomethacin 12 mg before exercise, plus Axert 12.5 mg. There was no treatment plan reported. The rationale was not submitted. The Request for Authorization was submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Axert tab 12.5mg, #36: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti Inflammatory (NSAIDS) (van Tulder-Cochrane,2000). Decision based on Non-MTUS Citation Official Disability Guidelines.

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

Decision rationale: The request for Axert tab 12.5 mg quantity 36 is non-certified. The Official Disability Guidelines for triptans state they are for migraine sufferers. At marketed doses all oral triptans (e.g. sumatriptan, brand name Imitrex) are effective and well tolerated. Differences among them are, in general, relatively small, but clinically relevant for individual. A poor response to 1 triptan does not predict a poor response to other agents in that class. According to the FDA Orange Book, equivalent generics have been approved for Maxalt, so generic rizatriptan would be recommended. The efficacy of this medication was not provided. Functional improvement and measurable gains were not reported. The frequency for this medication was not indicated. Although the injured worker has reported pain relief from the use of this medication, the request does not indicate a frequency for the medication. Therefore, the request is non-certified.

Indomethacin Cap 25mg, #30 with 3 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti Inflammatory medications see NSAIDs (Van Tulder-Cochrane,2000).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67.

Decision rationale: The request for indomethacin cap 25mg quantity 30, with 3 refills is non-certified. The California Medical Treatment Utilization Schedule Guidelines indicate that NSAIDs are recommended for short term symptomatic relief of low back pain. It is generally recommended that the lowest effective dose be used for all NSAIDs for the shortest duration of time, consistent with the individual patient treatment goals. There should be documentation of objective functional improvement and an objective decrease in pain. The physical examination did not provide objective functional improvement. The efficacy of this medication was not reported. Also, the request does not indicate a frequency for the medication. Therefore, the request is non-certified.

Naproxen Tab #60, with 5 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Inflammatory medications see NSAIDs (Van Tulder-Cochrane,2000).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 67.

Decision rationale: The request for naproxen tab quantity 60, with 5 refills is non-certified. The California Medical Treatment Utilization Schedule Guidelines indicate that NSAIDs are recommended for short term symptomatic relief of low back pain. It is generally recommended that the lowest effective dose be used for all NSAIDs for the shortest duration of time, consistent with the individual patient treatment goals. There should be documentation of objective functional improvement and an objective decrease in pain. The physical examination did not provide objective functional improvement. The efficacy of this medication was not reported.

Also, the request does not indicate a frequency for the medication. Therefore, the request is non-certified.