

Case Number:	CM14-0083942		
Date Assigned:	07/23/2014	Date of Injury:	09/10/2009
Decision Date:	09/19/2014	UR Denial Date:	05/27/2014
Priority:	Standard	Application Received:	06/05/2014

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 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 a 57-year-old female who reported an injury on 09/10/2009. Her diagnosis was noted to be lumbar spine degenerative disc disease. Prior treatments were noted to be medications and a transcutaneous electronic nerve stimulation unit. She was noted to have diagnostic tests including a magnetic resonance imaging (MRI) of the lumbar spine. The injured worker had a clinical evaluation on 05/05/2014, subjective complaints of chronic and ongoing neck and low back pain. The objective findings included hypertensive blood pressure and tenderness along the cervical and lumbar paraspinal muscles with pain and facet loading. The treatment plan was for a follow-up evaluation. The rationale for the request was not provided with the documentation submitted for review. A Request for Authorization form was provided and dated 05/05/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Protonix 20mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms & Cardiovascular Risk Page(s): 68-69.

Decision rationale: The request for Protonix 20mg #60 is not medically necessary. The California MTUS Chronic Pain Medical Treatment Guidelines recommend proton pump inhibitors with the use of NSAIDs for patients with risk for gastrointestinal events. Risk factors include greater than 65 years of age; history of peptic ulcer; gastrointestinal (GI) bleeding or perforation; concurrent use of aspirin, corticosteroids and/or an anticoagulant; or high dose/multiple NSAIDs. The documentation submitted for review does not indicate the injured worker fitting the criteria for a gastrointestinal event. In addition, the request fails to provide a dosage frequency. Therefore, the request for Protonix 20mg #60 is not medically necessary.

Electric Scooter: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee and Leg Chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee, Durable Medical Equipment (DME).

Decision rationale: The request for electric scooter is not medically necessary. The Official Disability Guidelines address durable medical equipment (DME), and recommend if there is a medical need, and if the device or system meets Medicare's definition of durable medical equipment. The documentation provided does not indicate the injured worker with significant immobility. The guidelines indicate that the DME must be customarily used to serve a medical purpose. The documentation submitted for review does not indicate a medical purpose for the scooter. Without additional documentation to support a medical necessity for an electronic scooter, the request for electric scooter is not medically necessary.

Mirtazapine 15mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants Page(s): 13-16.

Decision rationale: The request for Mirtazapine 15mg #30 is not medically necessary. The California MTUS Chronic Pain Medical Treatment Guidelines recommend antidepressants for chronic pain as a first line option for neuropathic pain, and as a possibility for non-neuropathic pain. Tricyclics are generally considered a first line agent, unless they are ineffective, poorly tolerated, or contraindicated. Analgesia generally occurs within a few days to a week, whereas antidepressant effect takes longer to occur. This medication, also known as Remeron, is in the drug class antidepressants. The documentation submitted for review does not indicate how long the injured worker has had use of the requested medication. Prior usage of the requested medication is not noted to be effective, according to the clinical evaluation. In addition, the

provider's request failed to indicate a dosage frequency. Therefore, the request for Mirtazapine 15mg #30 is not medically necessary.