

<b>Case Number:</b>	CM14-0089701		
<b>Date Assigned:</b>	08/08/2014	<b>Date of Injury:</b>	07/14/2012
<b>Decision Date:</b>	10/22/2014	<b>UR Denial Date:</b>	06/05/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/13/2014

### 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 injured worker is a 75 year-old female who was reportedly injured on July 14, 2012. The mechanism of injury is noted as fall type event. The most recent progress note dated July 28, 2014, indicates that there are ongoing complaints of mid-thoracic pain. The physical examination demonstrated a decrease in spine range of motion, tenderness to palpation, some muscle spasm and no specific neurologic dysfunction. Diagnostic imaging studies objectified ordinary disease of life degenerative changes. Previous treatment includes injection therapies, nerve blocks, multiple medications, physical therapy, and other pain management interventions. A request was made for multiple medications and was not certified in the pre-authorization process on June 5, 2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Norco 10/325 #150:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 91-94,101-102.

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

**Decision rationale:** Norco (hydrocodone/acetaminophen) is a short acting opiate used for the management of intermittent moderate to severe breakthrough pain. The MTUS treatment guidelines support short-acting opiates at the lowest possible dose to improve pain and function, as well as the ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects. The claimant has chronic mid-thoracic back pain. Review of the available medical records fails to documents any objective or clinical improvement in the level of pain or increase in overall functionality with the current regimen. As such, this request is not considered medically necessary as the standards outlined in the MTUS are not met.

**Fluoxetine 40mg #30:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guideline, Treatment in Workers Comp 18th edition, 2013 Updates, Pain Chapter

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG pain chapter updated October 2014

**Decision rationale:** This product is a medical food formulated to be consumed under supervision of a physician. However there is no peer-reviewed evidence to support the efficacy of this type of intervention. Therefore, the medical necessity has not been established.

**Omeprazole 20mg #30:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** This is a protein pump inhibitor useful for the treatment of gastroesophageal reflux disease. The progress notes presented for review do not indicate any complaints of gastritis, gastrointestinal dysfunction or offer any physical examination findings of such a medication is necessary. Therefore, based on the clinical information presented for review tempered by the parameters outlined in the MTUS this is not medically necessary.

**Soma 350mg #30:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 29.

**Decision rationale:** The MTUS specifically recommends against the use of soma and indicates that it is not recommended for long-term use. Based on the clinical documentation provided, the clinician does not provide rationale for deviation from the guidelines. As such with the very specific recommendation of the MTUS against the use of this medication, this medication is not medically necessary.

**Mag OX 400mg #30:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**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:** This is a dietary supplement for magnesium oxide. This is categorized as a vitamin supplement that is not supported in the MTUS to address chronic pain as the outcomes of not been established. The medical necessity is not present.

**DSS 250mg #90:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 77.

**Decision rationale:** This is an over-the-counter preparation that is Dioctyl sodium sulfosuccinate a treatment for constipation. The parameters noted for constipation are cited above. There are no complaints of constipation or physical examination findings indicating a need for such. The medical necessity has not been established.

**Senna #120:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 77.

**Decision rationale:** This is also an over-the-counter preparation that is a stool softener employing a Festival laxative. Again there are no complaints of constipation presented in the progress notes. Therefore the medical necessity for this preparation has not been established.

**Milk Magnesia 30ml 1 dose once daily to be taken with DSS and Senna, if DSS and Senna combination are ineffective or if no BM for 3 days # 1 bottle: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 77.

**Decision rationale:** This is also an over-the-counter preparation that is a stool softener employing a Festival laxative. Again there are no complaints of constipation presented in the progress notes. Therefore the medical necessity for this preparation has not been established.

**Right T6-T7 intercostal nerve block: 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), Treatment in Workers Comp 18th edition, 2013 Updates, Chapter, pain

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

**Decision rationale:** As outlined in the ODG (MTUS and ACOEM guidelines do not address) such a block is not recommended due to lack of evidence for use. There is insufficient clinical information presented and there are no double blinded studies to support such an intervention. Therefore, based on the clinical information presented the medical necessity has not been established.

**Pool membership to [REDACTED]: 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) Treatment Workers Compensation, Chapter, Low back, Gym membership

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) low back chapter updated August 2014

**Decision rationale:** According to the Official Disability Guidelines, (ACOEM and MTUS do not address) a gym membership is not recommended as a medical prescription unless a home exercise program has not been effective and there is need for additional equipment. Additionally treatment in a gym environment needs to be monitored and administered by medical professionals. According to the attached medical record there is no documentation that home exercise program is ineffective or in adequate. Considering this, the request for a gym membership is not medically necessary.

