

Case Number:	CM15-0130681		
Date Assigned:	07/17/2015	Date of Injury:	02/15/2001
Decision Date:	08/20/2015	UR Denial Date:	06/16/2015
Priority:	Standard	Application Received:	07/07/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 63-year-old male, who sustained an industrial injury on February 15, 2001. The initial diagnosis and symptoms experienced, by the injured worker, were not included. Treatment to date has included physical therapy, medication, psychotherapy and x-ray. Currently, the injured worker complains of low back pain and discomfort that radiates down both legs (right is greater than the left). He continues with neck and left shoulder pain described as cracking and popping. The injured worker is diagnosed with, musculoligamentous sprain of the cervical spine with left upper extremity radiculitis, tendinitis (left shoulder), musculoligamentous sprain of the lumbar spine, disc bulge C6-C7, ligamentous injury left ankle and large rotator cuff tear with retraction of the left shoulder. His work status is retired. A note dated December 11, 2014 states physical therapy was beneficial, improved his strength, and decreased his pain. A note dated March 17, 2015 states the injured worker requires medications to provide temporary relief from the physical symptoms of the industrial injury. A note dated June 9, 2015 states the injured worker experiences relief from Ibuprofen. Due to the injured workers continued complaint of pain, Methocarbamol 750 mg #90 -three time a day with 5 refills (muscle relaxer), Ibuprofen 800 mg #90 -one three times a day with 5 refills (for pain), Omeprazole 20 mg #30 -one daily with five refills (due to Ibuprofen use) and MRI of the lumbar spine is requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

Methocarbamol 750mg quantity 90 one three times a day with five refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for pain).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 63-66 of 127.

Decision rationale: Regarding the request for methocarbamol, Chronic Pain Medical Treatment Guidelines support the use of non-sedating muscle relaxants to be used with caution as a 2nd line option for the short-term treatment of acute exacerbations of pain. Within the documentation available for review, there is no identification of a specific analgesic benefit or objective functional improvement as a result of the medication. Additionally, it does not appear that this medication is being prescribed for the short-term treatment of an acute exacerbation, as recommended by guidelines. In the absence of such documentation, the currently requested methocarbamol is not medically necessary.

Ibuprofen 800mg quantity 90 one three times a day with five refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Non Steroidal Anti Inflammatory Drugs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 67-72 of 127.

Decision rationale: Regarding the request for ibuprofen, Chronic Pain Medical Treatment Guidelines state that NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Within the documentation available for review, there is no indication that ibuprofen is providing any specific analgesic benefits (in terms of percent pain reduction, or reduction in numeric rating scale), or any objective functional improvement. In the absence of such documentation, the currently requested ibuprofen is not medically necessary.

Omeprazole 20mg quantity 30 one daily with five refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Non Steroidal Anti Inflammatory Drugs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 68-69 of 127.

Decision rationale: Regarding the request for omeprazole (Prilosec), California MTUS states that proton pump inhibitors are appropriate for the treatment of dyspepsia secondary to NSAID therapy or for patients at risk for gastrointestinal events with NSAID use. Within the documentation available for review, while the patient is at risk for GI issues with NSAID

therapy, the NSAID has been determined to be not medically necessary. In light of the above issues, the currently requested omeprazole (Prilosec) is not medically necessary.

MRI of the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

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, MRIs (magnetic resonance imaging).

Decision rationale: Regarding the request for lumbar MRI, CA MTUS does not address repeat imaging. ODG cites that repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. Within the documentation available for review, there is no identification of any red flags, current clinical findings suggestive of radiculopathy, or a significant change in symptoms and/or findings suggestive of significant pathology. In the absence of clarity regarding those issues, the currently requested lumbar MRI is not medically necessary.