

Case Number:	CM15-0140417		
Date Assigned:	07/30/2015	Date of Injury:	08/10/2012
Decision Date:	09/17/2015	UR Denial Date:	06/25/2015
Priority:	Standard	Application Received:	07/20/2015

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 49 year old female who sustained an industrial injury on 8.10.12. The mechanism of injury was unclear. She currently complains of neck pain radiating down right upper extremity, right shoulder and forearm with numbness in the right upper extremity to the hand, muscle weakness, occipital headaches; low back pain that radiates down the right lower extremity with muscle weakness and muscle spasms bilaterally in the low back; lower extremity pain bilaterally in the knees and buttocks; occipital headaches. Her pain level was 3 out of 10 with medications and 6 out of 10 without medications. Her activities of daily living are limited in the areas of ambulation due to pain. On physical exam of the cervical spine there was spasm noted bilaterally C4-6, tenderness on palpation at bilateral paravertebral C4-6 area, occipital tenderness on palpation of the right side with painful range of motion; lumbar exam revealed spasms at L4-S1, tenderness on palpation in the bilateral paravertebral area L4-S1, decreased range of motion, decreased sensation along the L4-5 dermatome in the right lower extremity, positive seated straight leg raise on the right; upper extremity revealed tenderness on palpation at the right wrist, mild swelling; lower extremity revealed tenderness on palpation at the right knee with decreased range of motion due to pain. Medications were Cymbalta, Norflex, ibuprofen, Lidocaine 2% ointment, omeprazole, orphenadrine. Diagnoses include diabetes; cervical radiculitis; lumbar radiculitis; right knee internal derangement; status post right knee arthroscopy (12.29.14); chronic pain; cervical disc degeneration; cervical radiculopathy; lumbar radiculopathy; right wrist pain; chronic constipation; medication related dyspepsia. Treatments to date include medications; physical therapy; right occipital nerve block (8.5.14) with moderate

improvement; transforaminal epidural steroid injection right L4-5 (5.19.15) with 50-80% overall improvement with improved mobility and sleep. Diagnostics include MRI of the right knee (2.6.13) showing meniscal tear; MRI of the cervical spine (11.20.13) showing disc desiccation, disc protrusion; MRI of the lumbar spine (11.20.13) showing disc desiccation, disc protrusion, disc bulge; electromyography/ nerve conduction study (6.25.13) revealed normal electromyography and abnormal nerve conduction study showing moderate right carpal tunnel syndrome. In the progress note dated 6.2.15 the treating provider's plan of care included requests for ibuprofen 800mg #90; orphenadrine ER; omeprazole DR 30 mg #30; Enovarx-ibuprofen 10% Kit #1.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ibuprofen 800mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-72.

Decision rationale: Regarding the request for Motrin (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 Motrin is providing any objective functional improvement. In the absence of such documentation, the currently requested Motrin is not medically necessary.

Omeprazole DR 30mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Procedure Summary, Proton Pump Inhibitors.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines PPIs Page(s): 68-69.

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, there is no indication that the patient has complaints of dyspepsia secondary to NSAID use, a risk for gastrointestinal events with NSAID use, or another indication for this medication. In light of the above issues, the currently requested omeprazole (Prilosec) is not medically necessary.

Orphenadrine Citrate ER #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants. Decision based on Non-MTUS Citation Official Disability Guidelines, Anti- spasticity Drugs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63-66.

Decision rationale: Regarding the request for Orphenadrine Citrate, 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 objective functional improvement as a result of the Orphenadrine Citrate. Additionally, it does not appear that this medication is being prescribed for the short-term treatment of an acute exacerbation, as recommended by guidelines. Given this, the currently requested Orphenadrine Citrate is not medically necessary.

Enovarx-Ibuprofen 10% Kit #1: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 111-112.

Decision rationale: Regarding the request for Enovarx-Ibuprofen 10%, guidelines state that topical NSAIDs are recommended for short-term use. Oral NSAIDs contain significantly more guideline support, provided there are no contraindications to the use of oral NSAIDs. Within the documentation available for review, there is no documentation that the patient would be unable to tolerate oral NSAIDs, which would be preferred, or that the Enovarx-Ibuprofen 10% is for short term use, as recommended by guidelines. In the absence of clarity regarding those issues, the currently requested Enovarx-Ibuprofen 10% is not medically necessary.