

Case Number:	CM15-0193632		
Date Assigned:	10/07/2015	Date of Injury:	08/12/2014
Decision Date:	12/10/2015	UR Denial Date:	09/02/2015
Priority:	Standard	Application Received:	10/01/2015

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: Preventive Medicine, Occupational Medicine

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 52 year old male, who sustained an industrial-work injury on 8-12-14. A review of the medical records indicates that the injured worker is undergoing treatment for chronic low back strain, lumbar disc protrusions, and lumbar radiculopathy. Treatment to date has included pain medication including Omeprazole, Ibuprofen, Methoderm gel and Cyclobenzaprine since at least 8-3-15, diagnostics, physical therapy, work restrictions, back brace and other modalities. The current medications include Aleve and Excedrin. Medical records dated 8-3-15 indicate that the injured worker complains of back pain with symptoms in the right lower extremity (RLE) such as weakness and numbness rated 1-5 out of 10 on the pain scale. The medical records also indicate worsening--improvement of the activities of daily living. Per the treating physician report dated 8-3-15 the injured worker has returned to work. The physical exam dated 8-3-15 reveals decreased lumbar range of motion and moderately strong straight leg raise pain at 70 degrees with a peroneal nerve stretch sign. There is decreased sensation in L4-S1 for light touch. The physician indicates that he recommends medicinal support and a baseline urine drug screen to be performed. The request for authorization date was 8-3-15 and requested services included Omeprazole 20 mg #90, Ibuprofen 800 mg #60, Methoderm gel #1 and Cyclobenzaprine 10 mg #60 The original Utilization review dated 9-2-15 non-certified the request for Omeprazole 20 mg #90, Ibuprofen 800 mg #60, Methoderm gel#1 and Cyclobenzaprine 10 mg #60 as not medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

Omeprazole 20 mg #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 Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk.

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines, prior to starting the patient on a proton pump inhibitor, physicians are asked to evaluate the patient and to determine if the patient is at risk for gastrointestinal events. Criteria used are: (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID. There is no documentation that the patient has any of the risk factors needed to recommend the proton pump inhibitor omeprazole. Omeprazole 20 mg #90 is not medically necessary.

Ibuprofen 800 mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steroidal anti-inflammatory drugs).

Decision rationale: The MTUS recommends NSAIDs at the lowest dose for the shortest period in patients with moderate to severe pain. NSAIDs appear to be superior to acetaminophen, particularly for patients with moderate to severe pain. There is no evidence of long-term effectiveness for pain or function. The medical record contains no documentation of functional improvement. Guidelines recommend NSAIDs as an option for short term symptomatic relief. Ibuprofen 800 mg #60 is not medically necessary.

Menthoderm gel #1: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: Mentoderm Gel is a topical analgesic containing Methyl Salicylate 15.00% and Menthol 10.00%. According to the MTUS, there is little to no research to support the use of many of these Compounded Topical Analgesics. There is no peer-reviewed literature to support the use of topical Mentoderm Gel. Mentoderm gel #1 is not medically necessary.

Cyclobenzaprine 10 mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Cyclobenzaprine (Flexeril).

Decision rationale: The MTUS Chronic Pain Treatment Guidelines do not recommend long-term use of muscle relaxants such as cyclobenzaprine. The patient has been taking cyclobenzaprine for an extended period, long past the 2-3 weeks recommended by the MTUS. The clinical information submitted for review fails to meet the evidence based guidelines for the requested service. Cyclobenzaprine 10 mg #60 is not medically necessary.