

Case Number:	CM15-0048477		
Date Assigned:	03/20/2015	Date of Injury:	12/19/2007
Decision Date:	05/12/2015	UR Denial Date:	02/11/2015
Priority:	Standard	Application Received:	03/13/2015

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

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 reported an injury on 12/19/2007. The mechanism of injury was not provided. Her diagnoses were noted as cervical radiculopathy, lumbar radiculopathy, and shoulder impingement. During the assessment on 02/09/2015, the injured worker complained of significant pain as well as bilateral leg pain and burning. She reported that she was unable to sleep due to her pain and was losing more weight. The injured worker also indicated that she continued to have gastric symptoms, and the medications allowed her to function. The physical examination of the cervical spine revealed spasms in the paraspinal muscles. There was tenderness to palpation of the paraspinal muscles. There was reduced sensory in both hands and restricted range of motion. The physical examination of the shoulders revealed well-healed portals consistent with arthroscopic surgery of the right shoulder. There was tenderness to palpation of the anterior shoulder with restricted range of motion on the right. There was a positive impingement sign on the right. The physical examination of the lumbar spine revealed tenderness and spasm of the paraspinal muscles. There was reduced sensory in both feet and restricted range of motion. There was a positive straight leg raise in the sitting position bilaterally. The treatment plan was to have the injured worker continue taking the medication as before and to follow-up with the neurologist. The rationale for the request was not provided. The Request for Authorization form was dated 02/09/2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

Carisoprodol 350mg #60 with 2 refills: Upheld

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

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

Decision rationale: The request for Carisoprodol 350mg #60 with 2 refills is not medically necessary. The California MTUS Guidelines do not recommend the use of carisoprodol as the medication is not indicated for long-term use. The clinical documentation provided evidence that the injured worker had been on this medication for an extended duration of time, and there was a lack of documentation regarding objective functional improvement. Additionally, the frequency was not provided. As such, the request is not medically necessary.

Aciphex DR 20mg #60: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation National Guidelines Cleringhouse: Katz PO, Gerson LB, Vela MF. Guidelines for the diagnosis and management of gastroesophageal reflux disease. Am J Gastroenterol. 2013 Mar;108(3):308-28.

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

Decision rationale: The request for Aciphex DR 20mg #60 is not medically necessary. The California MTUS Guidelines state proton pump inhibitors are recommended for patients at intermediate or high risk for gastrointestinal events. Patients with no risk factor and no cardiovascular disease do not require the use of a proton pump inhibitor. The clinical documentation provided indicated that the injured worker continued to have gastric symptoms; however, there was no indication that the gastric symptoms were due to medication use. Additionally, the frequency was not provided. As such, the request is not medically necessary.

Lyrica 150mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs) Page(s): 16-18.

Decision rationale: The request for Lyrica 150mg #90 is not medically necessary. The California MTUS Guidelines recommend antiepilepsy medication as a first line medication for treatment of neuropathic pain. There should be documentation of an objective decrease in pain

of at least 30% to 50% and objective functional improvement. The clinical documentation did not indicate that there was an objective decrease in pain of at least 30% to 50% with the use of this medication. There was no documentation of objective functional improvement. Additionally, the frequency was not provided. Given the above, the request is not medically necessary.

Gabapentin 300mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs).

Decision rationale: The request for Gabapentin 300mg #90 is not medically necessary. The California MTUS Guidelines recommend antiepilepsy medication as a first line medication for treatment of neuropathic pain. There should be documentation of an objective decrease in pain of at least 30% to 50% and objective functional improvement. The clinical documentation did not indicate that there was an objective decrease in pain of at least 30% to 50% with the use of this medication. There was no documentation of objective functional improvement. Additionally, the frequency was not provided. Given the above, the request is not medically necessary.