

Case Number:	CM14-0130553		
Date Assigned:	08/20/2014	Date of Injury:	12/29/2010
Decision Date:	09/30/2014	UR Denial Date:	07/18/2014
Priority:	Standard	Application Received:	08/14/2014

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 records, presented for review, indicate that this 52-year-old individual was reportedly injured on December 30, 2010. The mechanism of injury was not listed in these records reviewed. The most recent progress note, dated July 11, 2014, indicated that there were ongoing complaints of low back pain. The physical examination demonstrated a 5'8", 270 pound individual to be hypertensive (177/115). There was no bruising, swelling or atrophy noted in the lumbar spine. No other physical examination findings relative to the lumbar spine are reported. Diagnostic imaging studies were not presented. Previous treatment included multiple medications. A request had been made for multiple medications and was not certified in the pre-authorization process on July 18, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Naproxen 550mg x 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAID's (non-steroidal anti-inflammatory).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 66, 73.

Decision rationale: As noted in the MTUS, this medication is recommended for the signs and symptoms of osteoarthritis. The markedly limited clinical records presented for review do not establish that there is osteoarthritis. A lumbar sprain/strain was noted. Therefore, when considering the date of injury, the injury sustained, the diagnosis offered and the insufficient clinical information presented for review and the parameters outlined in the MTUS, there is no clear clinical indication to establish the medical necessity of this medication. Therefore the request is not medically necessary.

Omeprazole 20mg x 60: Upheld

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

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

Decision rationale: This medication is a proton pump inhibitor useful for the treatment of gastroesophageal reflux disease. It can also be used as a gastric protectant against those individuals utilizing non-steroidal medications. However, when considering the date of injury, and the amount of time subsequent to that date of injury and that there are no complaints of gastritis or any gastrointestinal distress, there is no clinical information presented to support the need for this medication. Furthermore, it is also noted that there is no clinical indication for the continued use of non-steroidal medications. The medical necessity has not been established. Therefore the request is not medically necessary.

Tizanidine 4mg x 60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antispasticity/Antispasmodic Drugs Page(s): 66.

Decision rationale: Zanaflex (Tizanidine) is a centrally acting alpha 2-adrenergic agonist that is FDA approved for management of spasticity. It is unlabeled for use in low back pain. Muscle relaxants are only indicated as 2nd line options for short-term treatment. The physical examination does not support that there is a spinal cord injury type spasticity noted in the lower extremities. It appears that this medication is being used on a chronic basis, which is not supported by MTUS treatment guidelines. Therefore, this medication is not medically necessary.

Hydrocodone 10/325mg x 60: Upheld

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

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

Decision rationale: As noted in the MTUS, this medication is a short acting opioid indicated for the management of severe breakthrough pain. The progress notes did not indicate any physical examination findings to support a pathology that would require such medication. Additionally, there is no narrative presented to suggest that this medication has demonstrated any efficacy or utility in terms of increased functionality or decrease symptomology. Therefore, based on the limited records presented for review, the medical necessity for this preparation has not been established. Therefore the request is not medically necessary.

Quazepam 15mg X 30: 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), Pain Chapter; Insomnia Treatment.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 24.

Decision rationale: This medication is a benzodiazepine product noted as a sleep hypnotic. There are no clinical indications or subjective complaints of insomnia or other sleep disorder. Furthermore, this medication is not indicated for long-term, chronic or indefinite use as there are issues relative to addiction, tolerance or dependence. As such, the medical necessity for this preparation has not been established. Therefore the request is not medically necessary.

Gabapentin 10%/Dextromethorphan 10%/Amitriptyline 10%/ In Mediderm Base X 210 grams: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

Decision rationale: The MTUS guidelines state that topical analgesics are "largely experimental" and that "any compound product that contains at least one drug (or drug class), that is not recommended, is not recommended". Additionally, topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is no objective evidence of a neuropathic lesion. Therefore, the necessity for the Gabapentin has been limited. Accordingly, this compounded preparation is not considered medically necessary.

Flurbiprofen 20%/Tramadol 20% in Mediderm Base x 30 grams: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

Decision rationale: The MTUS guidelines state that topical analgesics are "largely experimental," and that "any compound product that contains at least one drug (or drug class), that is not recommended, is not recommended". Topical non-steroidal preparations are not supported in the MTUS. Accordingly, this compounded preparation is not considered medically necessary.

Amitriptyline 20%/Dextromethorphan 10%/ 10% Gabapentin In Mediderm Base X 210 grams: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

Decision rationale: The MTUS guidelines state that topical analgesics are "largely experimental" and that "any compound product that contains at least one drug (or drug class), that is not recommended, is not recommended". Additionally, topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is no objective evidence of a neuropathic lesion. Therefore, the necessity for the Gabapentin has been limited. Accordingly, this compounded preparation is not considered medically necessary.

Urine Toxicology Screen: 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 Criteria for Use of Opioids Page(s): (electronically cited).

Decision rationale: As outlined in the MTUS, the use of drug screening interventions are indicated if there are issues of abuse, addiction, poor pain control or evidence of drug diversions. The progress notes presented for you do not indicate any these situations exist. Therefore, based on the limited information presented, there is no clear clinical indication. Therefore the request is not medically necessary.

Flurbiprofen 20%/Tramadol 20% in Mediderm Base x210 grams: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

Decision rationale: The MTUS guidelines state that topical analgesics are "largely experimental" and that "any compound product that contains at least one drug (or drug class), that is not recommended, is not recommended". Topical non-steroidal preparations are not supported in the MTUS. Accordingly, this compounded preparation is not considered medically necessary.