

Case Number:	CM14-0137773		
Date Assigned:	09/05/2014	Date of Injury:	04/14/1998
Decision Date:	11/26/2014	UR Denial Date:	07/31/2014
Priority:	Standard	Application Received:	08/26/2014

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 Internal Medicine and is licensed to practice in New York. 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 case concerns a 47year old female who sustained an industrial injury on 04/14/1998. The mechanism of injury was not provided for review. Her diagnoses include late stage complex regional pain syndrome of the left upper and lower extremities, neck, and low back pain. She complains neck and low back pain that radiates down both arms and both legs. On physical exam there is tenderness to palpation of the cervical/thoracic/lumbar spine, tenderness over the stimulator generator site at the right buttock and marked weakness and contracture of the left upper and lower extremities. Treatment has included medical therapy with opiates, multiple surgeries, cervical spinal cord stimulator, and heat application. The treating provider has requested Prevacid 30mg #30, Lomotil 2.5 #90, and Ibuprofen 800mg # 90.

IMR ISSUES, DECISIONS AND RATIONALES

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

Prevacid 30MG, Qty. 30: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-inflammatory medications, NSAIDs.

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

Decision rationale: Per California MTUS 2009 proton pump inhibitors are recommended for patients taking Non-Steroidal Anti-Inflammatory Drugs (NSAID's) with documented Gastrointestinal (GI) distress symptoms or specific GI risk factors. There is documentation indicating the patient has symptoms of stomach pain, nausea and vomiting related to her medical therapy. She requires multiple medical therapies for treatment of her complex regional pain syndrome. GI risk factors include: age >65, history of peptic ulcer, GI bleeding, or perforation; concurrent use of aspirin, corticosteroids, and/or anticoagulants or high dose/multiple NSAID. Based on the available information provided for review, the medical necessity for Prevacid has been established. The requested medication is medically necessary.

Lomotil 2.5mg, Qty. 90: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.rxlist.com/lomotil-drug/indications-dosage.htm>

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Medscape Internal Medicine 2013: Lomotil

Decision rationale: The requested medication is medically necessary. The patient has intermittent diarrhea and bowel incontinence. Lomotil is an antidiarrheal and anticholinergic combination. She has responded to prn use of this medication. She requires multiple medical therapies for the treatment of her chronic pain condition. Medical necessity for the requested item has been established. The requested medication is medically necessary.

Ibuprofen 800mg, Qty. 90: Overturned

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

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

Decision rationale: The requested medication, Ibuprofen is medically necessary for the treatment of the claimant's pain condition. Ibuprofen is a non-steroidal anti-inflammatory medication (NSAID). These medications are recommended for the treatment of chronic pain as a second line therapy after acetaminophen. The documentation indicates the claimant has significant pain related to her complex regional pain syndrome and the medication has proved beneficial for pain control. The medication is tolerated with the use of a proton pump inhibitor. Medical necessity for the requested item has been established. The requested item is medically necessary.