

Case Number:	CM14-0140552		
Date Assigned:	09/10/2014	Date of Injury:	08/27/2009
Decision Date:	10/10/2014	UR Denial Date:	07/29/2014
Priority:	Standard	Application Received:	08/29/2014

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 & Rehabilitation & Pain Medicine and is licensed to practice in Oklahoma. 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 injured worker is a 40-year-old male who reported an injury on 08/27/2009. The mechanism of injury was not submitted for review. The injured worker has diagnoses of Chondromalacia patella, unspecified internal derangement of the knee, thoracic/lumbosacral neuritis or radiculitis unspecified and lumbago. Past medical treatments consist of facet injections, ESIs, physical therapy and medication therapy. Medications include Celebrex, glipizide, Lidoderm, metformin, methocarbamol, Norco, and omeprazole. On 01/23/2014 the injured worker underwent a drug screen which revealed that the injured worker was in compliance with his medications. On 08/06/2014 the injured worker complained of back pain. Physical examination had it noted that the injured worker stated his pain was 3/10 to 4/10 with medication and 7/10 to 8/10 without medication. It was noted that the injured worker had tenderness to palpation at the SI joint and lumbar muscle spasms, bilateral thoracic and lumbar paraspinal muscle spasms, and tenderness to palpation, right worse than left. It was noted that the injured worker had a range of motion of 70/0 to 5. The treatment plan is for the injured worker to continue the use of medications. The provider feels that the injured worker continues to suffer from back pain, which is improved with medications. It is noted that the injured worker only uses the medication when he is off of work, which usually totals 3 Norco per day. The Request for Authorization form was not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Omeprazole 20mg #30 with 1 refill: Upheld

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

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

Decision rationale: The request for Omeprazole 20mg #30 with 1 refill is not medically necessary. The California MTUS Chronic Pain Guidelines state that proton pump inhibitors may be recommended to treat dyspepsia secondary to NSAID therapy. The addition of the proton pump inhibitor is also supported for patients taking NSAID medications who have cardiovascular disease or significant risk factors for gastrointestinal events. The submitted documentation lacked any indication as to how long the injured worker had been on NSAID therapy. Additionally, there was no documented evidence that the injured worker had complaints of dyspepsia with the use of the NSAID therapy, or cardiovascular disease. In the absence of this documentation, the request is not supported by the evidence based guidelines. Additionally, the request as submitted did not indicate a duration or frequency of the medication. As such, the request for Omeprazole 20mg #30 with 1 refill is not medically necessary.

Methocarbamol 750mg #60 with 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain), Page(s): 63-65..

Decision rationale: The request for Methocarbamol 750mg #60 with 1 refill is not medically necessary. The California Medical Treatment Utilization Schedule Guidelines state in most low back pain cases, Robaxin shows no benefit beyond NSAIDs in pain and overall improvement. Also there is no additional benefit shown in combination with NSAIDs. The efficacy appears to diminish over time, and prolonged use of the same medication in this class may lead to dependence. The MTUS Guidelines also state that Methocarbamol is within the class of drugs with limited published evidence along with Chlorzoxazone, Dantrolene, and baclofen. The documentation submitted for review did not indicate whether the Methocarbamol had been effective this far. There was no quantified information regarding pain relief. As the injured worker did state that the medications were helping somewhat with pain, it was unclear as to what medications were helping. In addition, there was no assessment regarding intensity or longevity of pain relief. The MTUS Guidelines recommend that Methocarbamol be taken as directed, 1500 mg 4 times a day for the first 2 to 3 days, then decrease to 750 mg 4 times a day for no more than 4 weeks. Evidence in this submitted report indicated that the injured worker had been taking Robaxin since at least 10/2013, exceeding the recommended guidelines. Given the above, the request for methocarbamol is not supported by the MTUS Guidelines. As such, the request is not medically necessary.

