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| Case Number: | CM14-0142019 | | |
| Date Assigned: | 09/10/2014 | Date of Injury: | 05/02/2011 |
| Decision Date: | 10/29/2014 | UR Denial Date: | 08/14/2014 |
| Priority: | Standard | Application Received: | 09/02/2014 |

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 claimant is a 67 year old female who sustained an industrial injury on 05/02/2011. The mechanism of injury occurred when she tripped over an electric cord and fell while cleaning. Her diagnoses include cervical disc displacement with radiculitis, lumbar disc displacement, low back pain, thoracic pain and neck pain. She continues to complain of neck and low back pain. On physical exam there is decreased range of cervical motion with increased pain with all movements. Her motor strength in the upper extremities is 4/5 and sensation was diminished bilaterally in the upper extremities along the C4 dermatome and her Spurling's test was positive. The treatment has included medical therapy and epidural steroid injection therapy. The treating provider has requested Fluoxetine 20mg #120 1 po bid, Orphenadrine XR 100mg #30, 1 tab po qd prn, 30 days, Ketoprofen 75mg #120, 1 tab po qd/bid prn, 60 days, and Prilosec DR 20mg #60, 1-2 caps po qd, 60 days.

IMR ISSUES, DECISIONS AND RATIONALES

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

Fluoxetine 20mg #120, 1 tab po bid, 60 days: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG (Official Disability Guidelines) Mental Illness and Stress

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines California MTUS 2009 Page(s): 13- 16.

Decision rationale: The requested medication, Fluoxetine is not medically necessary for the treatment of the patient's condition. The claimant has no documented history of depression as part of his chronic pain condition. Fluoxetine is an antidepressant in the group of drugs called selective reuptake inhibitors (SSRIs). Medical necessity for the requested item has not been established. The requested item is not medically necessary.

Orphenadrine XR 100mg #30, 1 tab po qd prn, 30 days: 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 California MTUS 2009 Page(s): 41.

Decision rationale: Per the reviewed literature, muscle relaxants are not recommended for the long-term treatment of pain. These medications have their greatest effect in the first four days of treatment. The documentation does not indicate there are palpable muscle spasms and there is no documentation of functional improvement from any previous use of this medication. Per CA MTUS Guidelines muscle relaxants are not considered any more effective than nonsteroidal anti-inflammatory medications alone. Based on the currently available information, the medical necessity for chronic use of this muscle relaxant medication has not been established. The requested item is not medically necessary.

Ketoprofen 75mg #120, 1 tab po qd/bid prn, 60 days: Overturned

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 California MTUS 2009 Page(s): 70.

Decision rationale: The review of the medical documentation indicates the patient requires Ketoprofen therapy for her chronic pain condition. NSAIDs such as Ketoprofen are the traditional first line of treatment to reduce pain so activity and functional restoration can resume. A comprehensive review of clinical trials on the efficacy and safety of drugs for the treatment of chronic musculoskeletal pain has concluded that available evidence supports the effectiveness of non-selective nonsteroidal anti-inflammatory drugs in chronic pain conditions. Medical necessity for the requested item has been established. The requested treatment is medically necessary.

Prilosec DR 20mg #60, 1-2 caps po qd, 60 days: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines California MTUS 2009 Page(s): 68.

Decision rationale: Per California MTUS 2009 proton pump inhibitors are recommended for patients taking NSAIDs with documented GI distress symptoms or specific GI risk factors of age > 65 (67). 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. The patient is maintained on Ketoprofen therapy. Based on the available information provided for review, the medical necessity for Prilosec has been established. Medical necessity for the requested item has been established. The requested medication is medically necessary.