MAXIMUS Federal Services

Case Number:	CM14-0151480		
Date Assigned:	09/19/2014	Date of Injury:	10/01/1993
Decision Date:	10/20/2014	UR Denial Date:	08/20/2014
Priority:	Standard	Application Received:	09/17/2014

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 Occupational Medicine and is licensed to practice in California. 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 57-year-old male who sustained an injury on 10/01/1993. He is diagnosed with (a) mild degenerative disc disease L5-S1of the facet joints; (b) mild degenerative joint disease L5-S1 of the facet joints; and (c) negative for significant posterior disc protrusion and spinal stenosis per the March 6, 2000 Agreed Medical Evaluation report.He was seen on July 21, 2014 for an evaluation. He complained of low back pain, which was rated 8/10 and was described as an intermittent ache with periods of electric-type pain over the left lateral aspect of the low back. He also complained of right hip pain, which was rated 5-6/10 and was described as an intermittent ache that comes and goes. He reported left hip pain, which was rated 8/10 and was described as numbness and tingling with radiation to the fourth and fifth digits. The examination of the lumbar spine revealed limited range of motion. The straight leg raising test in the sitting position was negative and in the supine position was positive over the left lower extremity. He walked with a mildly antalgic gait without the use of any canes or assistive devices. The examination of the bilateral hips revealed limited range of motion.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ibuprofen 800mg #90 with 5 Refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, Specific Drug List & Adverse Effects Page(s): 72.

Decision rationale: The request for Ibuprofen 800mg #90 with 5 Refills is not medically necessary at this time. The Chronic Pain Medical Treatment Guidelines stated that this medication is recommended for osteoarthritis and off-label for ankylosing spondylitis. The injured worker is not diagnosed with any of these conditions. Furthermore, there was no documentation of the patient's subjective and objective response to ibuprofen in 800 mg as the guidelines made mention that doses greater than 400 mg have not shown to provide greater relief of pain. The request is not medically necessary.

Omeprazole 20mg #30 with 5 Refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms & Cardiovascular Risk.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), Proton Pump Inhibitors (PPIs)

Decision rationale: The request for Omeprazole 20mg #30 with 5 Refills is not medically necessary at this time. According to the Official Disability Guidelines, proton pump inhibitors are recommended for patients at risk for gastrointestinal events. From the medical records reviewed, there was no documentation of any gastrointestinal complaints in this worker. Additionally, as the request for Ibuprofen 800mg #90 with 5 Refills is not medically necessary, the request for Omeprazole 20mg #30 with 5 Refills is not considered medically necessary as well.

TENS Unit and Supplies: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS, Post-Operative Pain (Transcutaneous Electrical Nerve Stimulation) Page(s): 116-117.

Decision rationale: The request for the transcutaneous electrical nerve stimulation unit and supplies is not medically necessary at this time. According to the Chronic Pain Medical Treatment Guidelines, one of the criteria for the utilization of transcutaneous electrical nerve stimulation unit is that there should be evidence of trial and failure of other pain modalities including medications. Documentation of this information was not found in the reviewed of this worker's medical records. Hence, the request for TENS Unit and Supplies is not medically necessary.

1 Baseline Labs: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation University of Michigan Health System; August 2013, page 11

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, Specific Drug List & Adverse Effects Page(s): 70-73.

Decision rationale: The request for 1 Baseline Labs is not medically necessary at this time. It has been determined from the reviewed medical records that baseline lab was performed to assess the injured worker's ability to metabolize and excrete medications. As the requests for Ibuprofen 800 mg #90 with 5 Refills and Omeprazole 20 mg #30 with 5 refills were not medically necessary based on the Chronic Pain Medical Treatment Guidelines, the request for 1 Baseline Lab is not necessary as well.