

<b>Case Number:</b>	CM14-0025807		
<b>Date Assigned:</b>	07/02/2014	<b>Date of Injury:</b>	05/01/2002
<b>Decision Date:</b>	08/18/2014	<b>UR Denial Date:</b>	02/22/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/28/2014

### 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 Anesthesiology and Pain Medicine and is licensed to practice in Florida. 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 52-year-old male who reported an injury on 05/01/2002. The mechanism of injury was not provided for review. The injured worker reportedly sustained an injury to his neck, arm, hand, low back, and leg. The injured worker's chronic pain was managed with multiple medications. A letter of appeal in 10/2013 documented that the patient had developed gastrointestinal symptoms to include excess gas. This was treated with Gas-X. The patient was evaluated on 01/14/2014. It was documented that the patient had severe complaints of pain without the use of medications. The injured worker was evaluated on 02/10/2014. It was documented that the injured worker had an increase in swelling of the wrist and hands with significant neck, back, and leg pain. The injured worker's diagnoses included complex regional pain syndrome. The injured worker's treatment plan included continued medications as they were providing pain relief.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**GAS-X ES 125MG, #90 WITH 5 REFILLS:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation World Gastroenterology Organization (WGO) irritable bowel syndrome; a global perspective, Munich (Germany) 2009 Apr 20.20p.

**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:<http://www.webmd.com/drugs/mono-8265-simethicone+tablets%2Fcapsules+-+oral.aspx?drugid=9208&drugname=gas-x+oral>.

**Decision rationale:** California Medical Treatment Utilization Schedule (MTUS) and Official Disability Guidelines do not address this medication. The online resource WebMD documents that this medication is used to relieve symptoms of extra gas such as belching, bloating, and feelings of pressure and discomfort in the stomach. The clinical documentation submitted for review does indicate that the patient previously had these symptoms. However, the most recent clinical documentation does not provide an adequate assessment of the patient's gastrointestinal system to support ongoing use. Additionally, the request includes 5 refills. This does not allow for adequate or timely reassessment to establish efficacy and support continued use. Furthermore, the request as it is submitted does not provide a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Gas-X ES 125mg, #90 with 5 refills is not medically necessary or appropriate.

**OXYCONTIN 80MG, # 270:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-Going Management Page(s): 78.

**Decision rationale:** California Medical Treatment Utilization Schedule recommends the ongoing use of opioids in the management of chronic pain be supported by a quantitative assessment of pain relief, specific functional benefit, managed side effects, and evidence that the injured worker is monitored for aberrant behavior. The clinical documentation submitted for review does not provide a quantitative assessment of pain relief. Additionally, there is no documentation of specific functional benefit related to medication usage. Furthermore, the request as it is submitted does not clearly identify frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested OxyContin 80mg, #270 is not medically necessary or appropriate.