

Case Number:	CM15-0014074		
Date Assigned:	02/02/2015	Date of Injury:	07/20/2012
Decision Date:	03/30/2015	UR Denial Date:	01/22/2015
Priority:	Standard	Application Received:	01/26/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: California, Arizona
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 51-year-old female who reported an injury on 07/20/2012 due to an unspecified mechanism of injury. She reported low back pain rated at a 3/10, left greater than the right; and noted paresthesias in the left toes, triggered by picking up heavy objects, stepping off a car wrong, or while attempting to be intimate. Her medications included cyclobenzaprine HCl 7.5 mg by mouth, gabapentin 600 mg by mouth daily, omeprazole 20 mg take 20 mg by mouth daily, oxybutynin 5 mg take 5 mg by mouth 3 times a day, ibuprofen 800 mg take 800 mg by mouth nightly as needed, and levothyroxine 50 mcg tablets take 50 mcg by mouth daily. A physical examination of the low back showed no tenderness to palpation of the spinous process or paravertebral area, no muscle spasm, and no pain to percussion over the spinous processes. Forward flexion was limited to 15 degrees due to pain, 20 degree right and left lateral bending was noted; and she had a positive straight leg raise bilaterally with radiation down the posterior calf. Patellar reflexes were 1+ bilaterally, and lower extremity sensation was normal. She was diagnosed with lumbago and carpal tunnel syndrome. The treatment plan was for omeprazole 20 mg, Flexeril 7.5 mg, Neurontin 600 mg, and Methoderm gel. The rationale for treatment was not provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

Omeprazole 20mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs/GI Risks Page(s): 67-68.

Decision rationale: The California MTUS Guidelines indicate that proton pump inhibitors are recommended for the treatment of dyspepsia secondary to NSAID therapy and for those who are at high risk for gastrointestinal events due to NSAID therapy. Based on the clinical documentation submitted for review, the injured worker was noted to be symptomatic regarding the low back. However, there is a lack of documentation showing that she had dyspepsia secondary to NSAID therapy, or that she was at high risk for gastrointestinal events due to NSAID therapy to support the request. Also, the frequency and duration of the medication was not stated from the request. Therefore, the request is not supported. As such, the request is not medically necessary.

Flexeril 7.5mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants, Antispasticity drugs. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) TWC Pain Procedure Summary

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63.

Decision rationale: The California MTUS Guidelines indicate that non sedating muscle relaxants are recommended for the short term symptomatic relief of low back pain. The documentation provided does not show that the injured worker has had a quantitative decrease in pain or an objective improvement in function with the use of this medication to support its continuation. Also, the duration, the frequency, and quantity of the medication was not stated within the request. Furthermore, it is unclear how long the injured worker has been using this medication, and without this information, continuing would not be supported. Therefore, the request is not supported. As such, the request is not medically necessary.

Neurontin 600mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs (AEDs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin (Neurontin) Page(s): 49.

Decision rationale: The California MTUS Guidelines indicate that Neurontin is recommended as a first line therapy option for neuropathic pain. The documentation provided does not show

that the injured worker is having a quantitative decrease in pain or an objective improvement in function with the use of this medication to support its continuation. Also, the quantity of the medication and frequency was not stated within the request. Therefore, the request is not supported. As such, the request is not medically necessary.

Menthoderm Gel: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-114.

Decision rationale: The California MTUS Guidelines indicate that topical analgesics are recommended primarily for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There was no indication within the provided documentation that the injured worker was intolerant to or had tried and failed recommended oral medications to support the request for topical analgesics. Also, her response in terms of pain relief and functional improvement was not provided for review. Furthermore, the frequency, quantity, and dosage of the medication were not stated within the request. Therefore, the request is not supported. As such, the request is not medically necessary.