

Case Number:	CM15-0014329		
Date Assigned:	02/02/2015	Date of Injury:	08/03/2009
Decision Date:	03/30/2015	UR Denial Date:	01/23/2015
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, Washington

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 58-year-old female who reported injury on 06/03/2009. The mechanism of injury was the injured worker was pulling a trolley full of supplies. Prior therapies included chiropractic care. There was a Request for Authorization submitted for review dated 01/16/2015. The documentation of 08/25/2014 revealed the injured worker was complaining of pain in the low back with radiation to the right leg. The injured worker complained of stomach upset and indicated that Motrin worked better than Celebrex. The injured worker had left shoulder pain. The physical examination revealed the injured worker was limping on the right. The injured worker had asymmetric loss of motion in the lumbar spine and forward flexion. The injured worker had a positive Hawkins and weakness in the supraspinatus. The treatment plan included an MRI of the lumbar spine, chiropractic care, Percocet 5/325 mg #15, ibuprofen 800 mg, Zofran 4 mg #30 for nausea with medications, and a repeat urine drug screen.

IMR ISSUES, DECISIONS AND RATIONALES

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

Zofran 4mg QTY: 30.00: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Drugs.com/Zofran

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

Decision rationale: The Official Disability Guidelines indicate that antiemetics, ondansetron, are not recommended for nausea and vomiting secondary to chronic opioid use. The clinical documentation submitted for review indicated the injured worker had nausea and vomiting secondary to pain. The documentation indicating the medication was being taken for secondary effects of medication. The efficacy was not provided and there was a lack of documentation of exceptional factors to warrant nonadherence to guideline recommendations. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Zofran 4 mg quantity 30 is not medically necessary.

Ibuprofen 800mg QTY: 60.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-73.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 67.

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines recommend NSAIDs for the short term treatment of acute pain. There should be documentation of objective functional improvement and an objective decrease in pain. The clinical documentation submitted for review indicated the medication worked better for the injured worker. However, there was a lack of documentation of objective functional improvement and an objective decrease in pain. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Ibuprofen 800mg QTY: 60.00 is not medically necessary.

Magic mouthwash (Donnatol/Maalox/Lidocaine) 2% QTY: 1.00: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Drugs.com

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Barbiturate-containing analgesic agents (BCAs), Lidocaine Page(s): 23, 112. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Drugs.com.

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines do not support the use of barbiturate containing analgesic agents, and lidocaine in the form of anything other than Lidoderm patches is not supported. They do not however specifically address Maalox, and the Official Disability Guidelines do not address Maalox. As such, tertiary guidelines were sought. Per Drugs.com, Maalox is a combination of aluminum and magnesium for use as an antacid. The clinical documentation submitted for review indicated the injured

worker was having stomach upset. The specific rationale for the combination medication was not provided. There was a lack of documentation indicating necessity for both an antiemetic and magic mouthwash. The request as submitted failed to indicate the frequency and the dosage for the requested medication. Given the above, the request for Magic mouthwash (Donnatal/Maalox/Lidocaine) 2% QTY: 1.00 is not medically necessary.

Voltaren Gel 1% QTY: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics- Voltaren Gel (Diclofenac).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Voltaren Gel Page(s): 112.

Decision rationale: The California Medical Treatment Utilization Schedule guidelines indicate that Voltaren Gel 1% (diclofenac) is an FDA-approved agent indicated for relief of osteoarthritis pain in joints that lends themselves to topical treatment such as the ankle, elbow, foot, hand, knee, and wrist. It has not been evaluated for treatment of the spine, hip or shoulder. Maximum dose should not exceed 32 g per day (8 g per joint per day in the upper extremity and 16 g per joint per day in the lower extremity). The clinical documentation submitted for review failed to provide documented rationale for the use of the medication. The request as submitted failed to indicate the body part and the frequency for the requested medication. Given the above, the request for Voltaren Gel 1% QTY: 1.00 is not medically necessary.