MAXIMUS Federal Services

Case Number:	CM14-0155271		
Date Assigned:	09/25/2014	Date of Injury:	05/19/2007
Decision Date:	11/03/2014	UR Denial Date:	08/28/2014
Priority:	Standard	Application Received:	09/22/2014

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 Physical Medicine and Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Texas and Ohio. 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 54-year-old male who reported an injury on 05/19/2007 due to an unknown mechanism of injury. The injured worker reportedly sustained an injury to his neck and low back. The injured worker reportedly developed chronic pain that was managed with multiple medications. The injured worker was evaluated on 06/11/2014. It was documented that the injured worker had ongoing pain complaints rated at a 7/10 to 8/10. It was documented that the injured worker had ongoing abdominal complaints that were not alleviated with medications. The injured worker's medications included Prilosec 20 mg and Terocin patches. Objective findings included limited range of motion of the cervical and lumbar spine secondary to pain, with tenderness to palpation of the paravertebral musculature in the cervical and lumbar regions. The injured worker had 4+/5 left lower extremity motor strength and 5-/5 bilateral upper extremity motor strength. The injured worker's diagnoses included low back pain, ongoing headaches, depression, bilateral Achilles masses, left sided facial numbness and left side chest pain, upper and lower extremity paresthesias, degenerative disc disease of the cervical spine, cervical stenosis, and lumbar radiculopathy. The injured worker's treatment plan included the continued use of Prilosec, LidoPro cream, and Terocin patches. A Request for Authorization form dated 06/11/2014 was submitted to support the request.

IMR ISSUES, DECISIONS AND RATIONALES

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

Menthoderm Gel 4oz #1: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Salicylate topicals Page(s): 105.

Decision rationale: The requested Menthoderm Gel 4oz #1 is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does recommend the ongoing use of topical salicylates. However, the California Medical Treatment Utilization Schedule states that any medication used in the management of chronic pain should be supported by documented functional benefit and evidence of pain relief. The clinical documentation submitted for review does not provide an adequate assessment of the injured worker's pain to support a reduction in pain due to the use of Menthoderm. Therefore, the efficacy of this medication is not supported. Furthermore, the request as it is submitted does not provide an applicable body part. In the absence of this information the appropriateness of the request itself cannot be determined. As such, the requested Menthoderm Gel 4oz #1 is not medically necessary or appropriate.

Omeprazole 20mg # 120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 88.

Decision rationale: The requested Omeprazole 20mg # 120 is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends the ongoing use of gastrointestinal protectants be supported by an assessment of risk factors of gastrointestinal disturbances related to medication usage. The clinical documentation submitted for review does indicate that the injured worker has had ongoing abdominal complaints, unresponsive to medication. Therefore, the continued use of omeprazole would not be supported. Additionally, the clinical documentation does not provide an adequate assessment of the injured worker's gastrointestinal system to support that they are at continued risk for developing gastrointestinal events related to medication usage. Furthermore, the request as it is submitted does not clearly identify a frequency of treatment. In the absence of this information the appropriateness of the request itself cannot be determined. As such, the requested Omeprazole 20mg # 120 is not medically necessary or appropriate.