MAXIMUS Federal Services

Case Number:	CM13-0034138		
Date Assigned:	12/06/2013	Date of Injury:	04/28/2000
Decision Date:	03/24/2014	UR Denial Date:	09/11/2013
Priority:	Standard	Application Received:	10/11/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in Illinois. 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 physician 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 patient is a 58-year-old female who reported an injury on 04/28/2000, due to repetitive trauma that reportedly caused injury to her bilateral shoulders and upper extremities. Previous treatments have included physical therapy, medications, and carpal tunnel surgery. The patient developed chronic pain rated at an 8/10 without medications, reduced to a 5/10 to 6/10 with medications. The patient's medication schedule included Flexeril, Tramadol, and Gabapentin. Physical findings included tenderness to palpation of the bilateral shoulders, restricted range of motion bilaterally secondary to pain, a left-sided positive Neer's test, Hawkin's test, Yergason's test, and Speed's maneuver. The patient also had a positive Tinel's test, Phalen's test, reverse Phalen's test, Finkelstein's test, and 5th nerve compression test bilaterally. The patient's diagnoses included bilateral carpel tunnel syndrome, bilateral shoulder impingement, rotator cuff tears, SLAP lesion, chronic pain, pain-induced insomnia, cervical degenerative disc disease, and right little finger with trigger finger. The patient's treatment plan included recommendation for surgical intervention.

IMR ISSUES, DECISIONS AND RATIONALES

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

Omeprazole 20mg #60 with 3 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68.

Decision rationale: The requested omeprazole 20mg #60 with 3 refills is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends the use of gastrointestinal protectants for patients who are at risk for developing gastrointestinal disturbances related to long term medication usage. The clinical documentation submitted for review does not provide a thorough evaluation of the patient's gastrointestinal system to support that the patient is at risk for developing gastrointestinal disturbances related to medication usage. Additionally, it is noted in the patient's evaluation dated 02/07/2014, that the patient does not have any side effects related to medication usage. Therefore, the need for omeprazole 20 mg #60 with 3 refills is not medically necessary or appropriate.

Cyclobenzaprine 10mg #60 with 3 refills: Upheld

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

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

Decision rationale: The requested cyclobenzaprine 10 mg #60 with 3 refills is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does not recommend the extended use of muscle relaxants. The clinical documentation submitted for review does indicate that the patient has been on this medication for an extended duration of time. Additionally, the requested 3 refills extend treatment beyond guideline recommendations. The clinical documentation submitted for review does not provide any evidence of exceptional factors that support the need to extend treatment beyond guideline recommendations. As such, the requested cyclobenzaprine 10 mg #60 with 3 refills is not medically necessary or appropriate.

Gabapentin/Lidocaine 10%/2% Gel with 3 refills: Upheld

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

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

Decision rationale: The requested gabapentin/lidocaine 10%/2% gel with 3 refills is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does not recommend the use of gabapentin as a topical analgesic, as there is no scientific evidence to support the efficacy and safety of this medication as a topical agent. Additionally, the California Medical Treatment Utilization Schedule does not support the use of lidocaine in a gel formulation, as it is not FDA-approved in the treatment for neuropathic pain. The California Medical Treatment Utilization Schedule states that any compounded medication that contains at least 1 drug (or drug class) that is not supported by guideline recommendations, is not

recommended. As such, the requested gabapentin/lidocaine 10%/2% gel with 3 refills is not medically necessary or appropriate.