MAXIMUS Federal Services

Case Number:	CM13-0044997		
Date Assigned:	01/29/2014	Date of Injury:	01/31/2008
Decision Date:	04/30/2014	UR Denial Date:	10/11/2013
Priority:	Standard	Application Received:	10/31/2013

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 & Rehabilitation, has a subspecialty in Sports Medicine, and is licensed to practice in Texas. 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 patient is a 42-year-old female who reported an injury on 01/31/2008. The mechanism of injury was not provided for review. The patient reportedly sustained injury to the bilateral upper extremities and experienced emotional distress. The patient's treatment history includes multiple medications, physical therapy, acupuncture, and psychiatric support. The patient was evaluated on 09/17/2013 and it was documented that the patient had improvement with physical therapy. No physical examination was provided for review for this date. It was noted that the patient had bilateral shoulder tendinosis, bilateral medial and lateral epicondylitis, bilateral wrist sprain/strain with clinical evidence of carpal tunnel syndrome, and bilateral De Quervain's syndrome. The patient's treatment recommendations included activity modifications that limit repetitive motions, acupuncture, topical medication compound, Prilosec, Nizatidine, and Tylenol.

IMR ISSUES, DECISIONS AND RATIONALES

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

KETOPROFEN ULTRACREAM BID PRN 240GM WITH ONE REFILL: Upheld

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

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

Decision rationale: The requested Ketoprofen Ultracream twice a day as needed, 240 g with 1 refill is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does not support the use of ketoprofen as a topical agent as it is not FDA approved in this formulation. Although it is noted within the documentation that the patient has been using this medication since at least 07/2013, there is no documentation of significant functional benefit or pain relief to support extending treatment beyond guideline recommendations. As such, the Ketoprofen Ultracream as requested is not medically necessary or appropriate.

PRILOSEC 20MG BID #60 WITH ONE REFILL: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68.

Decision rationale: The requested Prilosec 20 mg twice a day, #60 with 1 refill is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends gastrointestinal protectants for patients who are at risk for developing gastrointestinal disturbances related to medication usage. The clinical documentation submitted for review does indicate that the patient has been on this medication since at least 11/2012. However, the patient's most recent clinical evaluation fails to provide an adequate assessment of the patient's gastrointestinal system to support that the patient is at risk for developing gastrointestinal events resulting from medication usage. The requested Prilosec 20 mg twice a day #60 with 1 refill is not medically necessary or appropriate.

NIZATIDINE 150MG ONE BID #60 WITH ONE REFILL: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation http://www.drugs.com/pro/nizatidine.html.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68.

Decision rationale: The requested Nizatidine 150 mg, 1 twice a day, #60 with 1 refill is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends gastrointestinal protectants for patients who are at risk for developing gastrointestinal disturbances related to medication usage. The clinical documentation submitted for review does indicate that the patient has been on this medication since at least 11/2012. However, the patient's most recent clinical evaluation fails to provide an adequate assessment of the patient's gastrointestinal system to support that the patient is at risk for developing gastrointestinal events resulting from medication usage. The requested Nizatidine 150 mg 1 twice a day, #60 with 1 refill is not medically necessary or appropriate.