

Case Number:	CM13-0069026		
Date Assigned:	01/03/2014	Date of Injury:	03/12/2011
Decision Date:	06/02/2014	UR Denial Date:	11/22/2013
Priority:	Standard	Application Received:	12/20/2013

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 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 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 63-year-old female who reported an injury on 3/12/11. The mechanism of injury was not provided for review. Current diagnoses include status post right shoulder arthroscopic surgery on 12/8/12, gastroesophageal reflux disease (GERD), and cervical spine myofascial pain syndrome. The injured worker was evaluated on 7/15/13. She reported constant neck pain with radiation to the bilateral upper extremities, and lower back pain with radiation to the bilateral lower extremities. Physical examination revealed 2+ trigger points in the cervical spine, limited shoulder range of motion, weakness in the upper extremities, and intact sensation. Treatment recommendations included continuation of current medication.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 PRESCRIPTION OF MOTRIN 800MG, 1 TAB ORALLY, 3 TIMES PER DAY WITH MEALS, #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67-72.

Decision rationale: California MTUS guidelines state that NSAIDs are recommended for osteoarthritis at the lowest dose for the shortest period of time for patients with moderate to severe pain. For acute exacerbations of chronic pain, NSAIDs are recommended as an option for short-term symptomatic relief. As per the submitted documentation, the injured worker reports persistent neck and lower back pain. The injured worker also maintains a diagnosis of GERD secondary to prolonged usage. Additionally, guidelines do not recommend long term use of this medication. As such, the request is not medically necessary.

PRESCRIPTION OF PRILOSEC 20MG, 1 TAB ORALLY, DAILY: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68-69.

Decision rationale: California MTUS guidelines state that proton pump inhibitors are recommended for patients at intermediate or high risk for gastrointestinal events. Patients with no risk factor and no cardiovascular disease do not require the use of a proton pump inhibitor. There is no evidence of cardiovascular disease or increased risk factors for gastrointestinal events in this patient. There is also no quantity listed in the current request. As such, the request is not medically necessary.

PRESCRIPTION OF TOPICAL CREAM MEDICATION: FLURBIPROFEN 20%GEL 120GM (TO BE APPLIED TO THE AFFECTED AREA 2-3 TIMES DAILY AS DIRECTED BY PHYSICIAN): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

Decision rationale: California MTUS guidelines state that topical analgesics are largely experimental in use with few randomized controlled trials to determine their efficacy or safety. The only FDA approved topical NSAID is Diclofenac. There is also no quantity listed in the current request. As such, the request is not medically necessary.

PRESCRIPTION OF TOPICAL CREAM MEDICATION: KETOPROFEN 20% + KETAMINE 10%GEL 120GM (TO BE APPLIED TO THE AFFECTED AREA 2-3 TIMES DAILY AS DIRECTED BY PHYSICIAN): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 56,111,113.

Decision rationale: California MTUS guidelines state that topical analgesics are largely experimental in use with few randomized controlled trials to determine their efficacy or safety. The only FDA approved topical NSAID is Diclofenac. There is also no quantity listed in the current request. As such, the request is not medically necessary.

PRESCRIPTION OF TOPICAL CREAM MEDICATION: GABAPENTIN 10% + CYCLOPENZAPRINE 10% WITH 0.375% CAPSAICIN 120GM (TO BE APPLIED TO THE AFFECTED AREA 2-3 TIMES DAILY AS DIRECTED BY PHYSICIAN): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

Decision rationale: California MTUS guidelines state that topical analgesics are largely experimental in use with few randomized controlled trials to determine their efficacy or safety. The only FDA approved topical NSAID is Diclofenac. There is also no quantity listed in the current request. As such, the request is not medically necessary.