

Case Number:	CM14-0104643		
Date Assigned:	09/16/2014	Date of Injury:	08/22/2013
Decision Date:	10/15/2014	UR Denial Date:	06/25/2014
Priority:	Standard	Application Received:	07/08/2014

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 Family Medicine, and is licensed to practice in California. 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 54-year-old female who has submitted a claim for lumbar radiculopathy and gastroduodenal disorder associated with an industrial injury date of August 22, 2013. Medical records from 2014 were reviewed. The patient complained of right shoulder and hand pain. She also complained of low back pain radiating to the right lower extremity. The patient has a history of peptic ulcer disease discovered in 2006 which was controlled with medications. Examination of the right upper extremity showed tenderness over the rotator cuff, medial and lateral epicondyle, over the volar carpal area, and the extensor aspect of the wrist; positive impingement test of the shoulder, positive Tinel's and Phalen's tests of the elbow and wrist, and positive Finkelstein test. Examination of the lumbar spine showed tenderness over the paravertebral muscles with spasm; limitation of motion; bilaterally positive SLR; and reduced sensation over the bilateral L5 dermatomal distribution. The diagnoses were right shoulder chronic strain with intra articular rotator cuff tear pathology with impingement; chronic right wrist strain with extensor tenosynovitis of the thumb; right carpal tunnel syndrome; lumbar radiculopathy; anxiety; and gastroduodenal disorders. Treatment to date has included Medrox pain relief ointment, Omeprazole, Carisoprodol, Naproxen, Lexapro, Ativan, Estazolam, Zantac, aqua therapy, and acupuncture. Utilization review from June 25, 2014 denied the request for Omeprazole DR 20mg, one daily QTY: 30, refills 2. Utilization review dated May 30, 2014 has certified request for 3 months' supply of Omeprazole. The request for Carisoprodol 350mg, one twice daily QTY: 60, refills 2 was also denied. Documentation does not identify presence of spasticity, and there was no documentation of significant functional/vocational benefit with the use of muscle relaxants. Lastly, the request for Voltaren 1% gel was denied. However, the reason for denial was not provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

Omeprazole DR 20mg, one daily QTY: 30, refills 2: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk.

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

Decision rationale: According to page 68 of CA MTUS Chronic Pain Medical Treatment Guidelines, proton pump inhibitors should be prescribed in patients on NSAID therapy who are at risk for GI events. Risk factors includes age > 65; history of peptic ulcer, GI bleed, or perforation; concurrent use of ASA, corticosteroids, or anticoagulant; and high dose or multiple NSAID use. Use of PPI > 1 year has been shown to increase the risk of hip fracture. Patients with intermediate or high risk factors should be prescribed proton pump inhibitor. In this case, the patient has a history of peptic ulcer disease diagnosed in 2006 and has been taking Omeprazole as far back as February 2014. Concomitant NSAID use was also noted. Due to increased risk for developing adverse GI events, PPI use is beneficial. However, it was noted that utilization review from May 30, 2014 certified the request for 3 months' supply of Omeprazole. The formal report was not provided. The medical necessity cannot be established because the patient should still have sufficient supply of medication when this request was applied on June 25, 2014. There was no compelling rationale concerning the need for additional supply of Omeprazole. Therefore, the request for Omeprazole DR 20mg, one daily QTY: 30, refills 2 is not medically necessary.

Carisoprodol 350mg, one twice daily QTY: 60, refills 2: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol (Soma); Carisoprodol (Soma, Soprodal 350TM, Vanadom, generic available) Page(.

Decision rationale: As stated on pages 29 and 65 of CA MTUS Chronic Pain Medical Treatment Guidelines, Carisoprodol is not recommended and is not indicated for long-term use. It is a commonly prescribed centrally acting skeletal muscle relaxant whose primary active metabolite is meprobamate (a schedule-IV controlled substance). Carisoprodol is now scheduled in several states but not on a federal level. It has been suggested that the main effect is due to generalized sedation and treatment of anxiety. In this case, Soma intake was noted as far back as February 2014. The guideline does not recommend Carisoprodol and its long-term use. Moreover, there was no objective evidence of overall pain improvement and functional benefits derived from its use. The medical necessity has not been established. There was no compelling

rationale concerning the need for variance from the guideline. Therefore, the request for Carisoprodol 350mg, one twice daily QTY: 60, refills 2 is not medically necessary.

Voltaren 1% gel: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, Voltaren Gel 1% (diclofenac) Page(s): 111-112.

Decision rationale: Page 67-68 of the CA MTUS Chronic Pain Medical Treatment Guidelines state that Voltaren Gel is indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). It has not been evaluated for treatment of the spine, hip or shoulder. In this case, the patient has low back, shoulder and wrist complaints. The request did not specify body part for treatment. The guideline does not support the use of this topical medication for shoulder and spine pain. The medical necessity cannot be established. There was no compelling rationale concerning the need for variance from the guideline. In addition, the request did not specify amount of medication to dispense. Therefore, the request for Voltaren 1% gel is not medically necessary.