

Case Number:	CM14-0019111		
Date Assigned:	04/23/2014	Date of Injury:	01/31/1994
Decision Date:	08/11/2014	UR Denial Date:	01/17/2014
Priority:	Standard	Application Received:	02/14/2014

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, and is licensed to practice in Nevada. 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 records presented for review indicate that this 53-year-old male was reportedly injured on January 31, 1994. The mechanism of injury was noted as a slip and fall type event. The most recent progress note, dated January 24, 2014, indicated that there were ongoing complaints of neck and low back pains. The physical examination demonstrated an individual with a history of hypertension, osteoarthritis and myocardial infarction. The injured employee was well-developed, well-nourished and in no acute distress. Single point cane was required for ambulation. A decrease in range of motion of the bilateral shoulders was noted as well as a positive Hawkins sign. A decrease in lumbar spine range of motion was noted associated with tenderness to palpation of the paravertebral musculature. Facet joint loading was uncomfortable. Motor function was noted to be 5/5, and there was a slight diminished sensation in the L5 and S1 dermatomes. Diagnostic imaging studies objectified degenerative changes. Previous treatment included electrodiagnostic assessment, enhanced imaging studies, epidural steroid and sacroiliac joint injections, total knee arthroplasty and bilateral rotator cuff repairs, multiple medications, physical therapy, TENS, and psychotherapy. A request had been made for omeprazole and a wheeled scooter and was not certified in the pre-authorization process on January 7, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

OMEPRAZOLE 40MG, #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68 OF 127.

Decision rationale: Prilosec (Omeprazole) is a proton pump inhibitor useful for the treatment of gastroesophageal reflux disease (GERD) and is considered a gastric protectant for individuals utilizing non-steroidal anti-inflammatory medications. There was no indication in the record provided of a GI disorder and the face of multiple complaints of pain in various aspects of the person. Additionally, the claimant did not have a significant risk factor for potential GI complications as outlined by the Chronic Pain Medical Treatment Guidelines. Therefore, the use of this medication is not medically necessary.

LIDOCAINE 5% PATCHES, #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 56, 112.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 56 OF 127.

Decision rationale: The Chronic Pain Medical Treatment Guidelines support the use of topical lidocaine for individuals with neuropathic pain who have failed treatment with first-line therapy including antidepressants or anti-epileptic medications. Based on the clinical documentation provided, the claimant has undergone bilateral total knee and bilateral shoulder surgeries. However, there was no objectification of a specific neuropathic lesion. The pain generators appeared to be nociceptive in nature. As such, the request is not considered medically necessary at this time.

WHEELED SCOOTER: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 99 OF 127.

Decision rationale: As noted in the Chronic Pain Medical Treatment Guidelines, these types of devices are not recommended if the functional mobility deficit can be sufficiently resolved by the prescription of a cane or walker, or if a manual wheelchair will suffice. The progress note indicated that the injured employee had been compliant with a single point cane. Mobilization and exercise were encouraged in every aspect of the treatment. As such, the medical necessity for this device has not been established in the progress notes presented for review.