

Case Number:	CM14-0035808		
Date Assigned:	07/23/2014	Date of Injury:	05/02/2012
Decision Date:	10/14/2014	UR Denial Date:	02/28/2014
Priority:	Standard	Application Received:	03/24/2014

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 Texas and Ohio. 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 56-year-old female who reported an injury on 05/02/2012. The mechanism of injury was not submitted for clinical review. The diagnoses included cervical spine strain, lumbar spine strain, bilateral shoulder impingement syndrome, bilateral epicondylitis, and bilateral carpal tunnel syndrome. The previous treatments included medication and physical therapy. Within the clinical note dated 03/05/2014, it was reported the injured worker complained of limited range of motion to the bilateral knees with significant pain to the low back which radiated to the bilateral lower extremities. On physical examination, the provider noted the injured worker had paraspinal muscle tenderness with spasms and restricted range of motion of the cervical spine. The provider noted the injured worker had joint line tenderness to the bilateral wrists. The request submitted is for ketoprofen, Omeprazole DR, zolpidem tartrate, carisoprodol, hydrocodone/APAP, and Voltaren gel. However, a rationale was not provided for clinical review. The request for authorization was not submitted for clinical review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ketoprofen 75mg, once per day, #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs), Page(s): 66-67, 72..

Decision rationale: The request for Ketoprofen 75mg, once per day, #30 is not medically necessary. The California MTUS Guidelines, ketoprofen is used for osteoarthritis and mild to moderate pain. The medication is recommended for a short period of time. There is lack of documentation to indicate the efficacy of the medication as evidenced by significant functional improvement. There is lack of documentation indicating the injured worker is treated for osteoarthritis. The provider failed to document an adequate and complete pain assessment within the documentation. Therefore, the request is not medically necessary.

Omeprazole DR 20mg, once a day, #30: 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 GI symptoms & cardiovascular risk, Page(s): 68-69.

Decision rationale: The request for Omeprazole DR 20mg, once a day, #30 is not medically necessary. The California MTUS Guidelines state proton pump inhibitors such as Omeprazole are recommended for injured workers at risk for gastrointestinal events and/or cardiovascular disease. The risk factors for gastrointestinal events include over the age of 65, history of peptic ulcer, gastrointestinal bleeding, or perforation, use of corticosteroids and/or anticoagulants. In the absence of risk factors for gastrointestinal bleeding events, proton pump inhibitors are not indicated when taking NSAIDs. The treatment of dyspepsia from NSAID usage includes stopping the NSAID, switching to a different NSAID, adding an H2 receptor antagonist or proton pump inhibitor. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The documentation submitted did not indicate the injured worker had a history of peptic ulcer, gastrointestinal bleed, or perforation. It did not appear the injured worker was at risk for gastrointestinal events. Additionally, there is lack of clinical documentation indicating the injured worker had a diagnosis of dyspepsia secondary to NSAID therapy. Therefore, the request is not medically necessary.

Zolpidem Tartrate 10mg, one tablet by mouth at bedtime, #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Insomnia Treatment

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain, Zolpidem.

Decision rationale: The request for Zolpidem Tartrate 10mg, one tablet by mouth at bedtime, #30 is not medically necessary. The Official Disability Guidelines note zolpidem is a prescription short acting non-benzodiazepine hypnotic, which is approved for short term, usually

2 to 6 weeks treatment of insomnia. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. There is lack of documentation indicating the injured worker is treated for insomnia. There is lack of objective and subjective documentation indicating the injured worker had sleep issues. Additionally, the injured worker has been utilizing the medication since 03/2014 which exceeds the guideline recommendations of short term use of 2 to 6 weeks. Therefore, the request is not medically necessary.

Carisprodol 350mg, one tablet by mouth two times per day, #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Carisprodol (Soma).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants, Page(s): 63, 64.

Decision rationale: The request for Carisprodol 350mg, one tablet by mouth two times per day, #60 is not medically necessary. The California MTUS Guidelines recommend non-sedating muscle relaxants with caution as a second line option for short term treatment of acute exacerbation in patients with chronic low back pain. The guidelines state the medication is not recommended to be used for longer than 2 to 3 weeks. The injured worker has been utilizing the medication for an extended period of time since at least 03/2014 which exceeds the guideline recommendations of short term use of 2 to 3 weeks. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. Therefore, the request is not medically necessary.

Hydrocodone/APAP 10/325mg, two tablets by mouth three times per day, #180: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids (Criteria for use).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use, On-Going Management, Page(s): 78.

Decision rationale: The request for Hydrocodone/APAP 10/325mg, two tablets by mouth three times per day, #180 is not medically necessary. The California MTUS Guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The guidelines recommend the use of urine drug screen or inpatient treatment with issues of abuse, addiction, or poor pain control. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The provider failed to document an adequate and complete pain assessment within the documentation. The use of a urine drug screen was not provided for clinical review. The injured worker has been utilizing the medication since at least 03/2014. Therefore, the request is not medically necessary.

Voltaren 1% Gel: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical NSAIDs Page(s): 111-112..

Decision rationale: The request for Voltaren 1% Gel is not medically necessary. The California MTUS Guidelines recommend topical NSAIDs for osteoarthritis and tendonitis, in particular that of the knee and/or elbow and other joints that are amenable. Topical NSAIDs are recommended for short term use of 4 to 12 weeks. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. The request submitted failed to provide the treatment site. Therefore, the request is not medically necessary.