MAXIMUS Federal Services

Case Number:	CM14-0038043		
Date Assigned:	06/25/2014	Date of Injury:	08/17/2010
Decision Date:	08/05/2014	UR Denial Date:	03/19/2014
Priority:	Standard	Application Received:	04/01/2014

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 California and Washington. 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 59-year-old female who reported injury on 08/17/2010. The mechanism of injury was not provided. The injured worker's medication history included omeprazole 20 mg 1 capsule twice a day, gabapentin 300 mg 2 capsules at bedtime and Voltaren Gel as of 04/2013. The mechanism of injury was the injured was working when she felt a sharp pain. Ibuprofen was added as of 11/2013. Documentation of 05/27/2014 revealed the injured worker had complaints of shoulder joint pain. The injured worker indicated she had been having stomach pain associated with medication use. The injured worker noted adverse effects of fatigue with the use of Ketoprofen. The diagnoses included the history of operative procedure on shoulder, fibromyositis, carpal tunnel syndrome, and adhesive capsulitis of the shoulder, shoulder joint pain, and observation of other suspected mental condition as well as shoulder joint replacement. The discussion notes indicated the injured worker had some stomach pain with the use of Ketoprofen and omeprazole was prescribed to help with medication-induced gastritis. It was indicated that the injured worker had taken gabapentin for pain with relief and the injured worker was using Voltaren Gel for topical pain which the injured worker found particularly helpful for localized areas of pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

Voltaren 1% gel 100 gm with 2 refills: Upheld

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

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

Decision rationale: California MTUS states Voltaren Gel 1% (diclofenac) is an FDA-approved agent indicated for relief of osteoarthritis pain in joints that lends themselves to topical treatment such as the ankle, elbow, foot, hand, knee, and wrist. It has not been evaluated for treatment of the spine, hip or shoulder. Maximum dose should not exceed 32 g per day (8 g per joint per day in the upper extremity and 16 g per joint per day in the lower extremity). The clinical documentation submitted for review indicated the injured worker had been utilizing the medication since at least 04/2013. The objective functional benefit was not provided. An objective decrease in pain was not provided. The request as submitted failed to indicate the frequency for the requested medication. The clinical documentation submitted for review failed to provide the necessity for 2 refills without re-evaluation. Given the above, the request for Voltaren 1% gel, 100 gm with 2 refills is not medically necessary.

Ibuprofen 600 mg #90 with 2 refills: Upheld

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

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

Decision rationale: The California MTUS Guidelines recommend NSAIDS for the short-term symptomatic relief of pain. It is generally recommended that the lowest effective dose be used for all NSAIDS for the shortest duration of time consistent with the individual patient treatment goals. There should be documentation of objective functional improvement and an objective decrease in pain. The clinical documentation submitted for review failed to provide documentation of the above criteria. The duration of use was since at least 11/2013. The specific request for ibuprofen was not supplied with the documentation. There was lack of documentation indicating a necessity for 2 refills without re-evaluation. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for ibuprofen 600 mg #90 with 2 refills is not medically necesarry.

Gabapentin 300 mg #30 with 2 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs (AEDs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepileptic Medications Page(s): 16.

Decision rationale: The California MTUS Guidelines recommend anti-epilepsy medications as a first line medication for the treatment of neuropathic pain. There should be documentation of an objective decrease in pain of at least 30-50% and documentation of objective functional improvement. The clinical documentation submitted for review indicated the injured worker had utilized the medication. However, there was lack of documentation of an objective decrease in pain of at least 30-50% and objective functional improvement. The documentation indicated the injured worker had utilized the medications since at least April 2013. The request as submitted failed to indicate the frequency for the requested medication. There was lack of documentation indicating a necessity for 2 refills without re-evaluation. Given the above, the request for gabapentin 300 mg #30 with 2 refills is not medically necessary.

Omeprazole 20 mg #30 with 2 refills: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines-Pain Chapter/Proton Pump Inhibitors.

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

Decision rationale: The California MTUS Guidelines recommend PPIs for the treatment of dyspepsia secondary to NSAID therapy. Clinical documentation submitted for review indicated the injured worker had been utilizing the medication since at least 04/2013. There was lack of documented efficacy. There was lack of documentation indicating a necessity for 2 refills without re-evaluation. The request as submitted failed to indicate the frequency for the requested medication. Give the above, the request for omeprazole 20 mg #30 with 2 refills is not medically necessary.