

Case Number:	CM14-0044965		
Date Assigned:	07/02/2014	Date of Injury:	11/04/2012
Decision Date:	08/22/2014	UR Denial Date:	03/26/2014
Priority:	Standard	Application Received:	04/12/2014

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 & Rehabilitation, has a subspecialty in Pain Medicine 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 50-year-old male who reported an injury on 11/04/2012; reportedly fell while assisting a recipient in the shower. The injured worker's treatment history included medications, acupuncture treatment, and cortisone injections. The injured worker was evaluated on 04/23/2014 and it was documented that the injured worker had no significant improvement since the last exam. The injured worker continued to have right knee pain and instability. He also continued to have left shoulder pain and back as well as LUE. He takes medication for pain which allows him to function throughout the day. The injured worker was having depressive symptoms that began since the date of injury and are worsening. Physical examination of the left shoulder revealed anterior shoulder was tender to palpation and range of motion was decreased flexion/abduction plane. Positive impingement sign. Lumbar spine paravertebral muscles tender and spasm was present. Range of motion was restricted. Deep tendon reflexes were normal and symmetrical. Sensation and motor strength are grossly intact. Straight leg raising test was positive on the left. Right knee joint line was tender to palpation. Positive McMurray's joint effusion was noted. Diagnoses included shoulder impingement, lumbar radiculopathy, and internal derangement of the knee not otherwise specifically. Medications included Carisoprodol 350 mg, Ketoprofen 75 mg, Omeprazole 20 mg, Norco 5/325 mg, and Voltaren 1% gel. The documentation submitted lacked evidence of the injured worker having any GI symptoms. The Request for Authorization dated 02/11/2014 was for Carisoprodol 350 mg, Voltaren 1% gel, Omeprazole 20 mg, and Hydrocodone 5/325 mg. The rationale was not submitted for this review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Carisprodol 350mg #60 Refill 2: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM, Chronic Pain Treatment Guidelines Muscle relaxant.

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

Decision rationale: The requested is not medically necessary. The California (MTUS) Chronic Pain Medical Guidelines recommend non-sedating muscle relaxants with caution as a second line option for short term treatment of acute exacerbations in patients with chronic LBP. Furthermore, there was lack of documentation on the injured worker using the VAS scale to measure functional improvement after the injured worker takes the medication. The request lacked frequency and duration of medication. In addition, the guidelines do not recommend Carisoprodol to be used for long term use. Given the above, the request for Carisoprodol 350mg # 60 with 2 refills is not medically necessary.

Omeprazole 20mg #30 Refill 2: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Proton-pump inhibitor.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Proton pump inhibitors, page(s) 68-69 Page(s): 63-64.

Decision rationale: The request is not medically necessary. Prilosec is recommended for patients taking NSAIDs who are at risk of gastrointestinal events. The documentation did not indicate the injured worker having gastrointestinal events. The provider failed to indicate the frequency of medication on the request that was submitted. There was lack of documentation of conservative care outcome measurements such as home exercise regimen. In addition, the provider failed to indicate long term functional goals or medication pain management outcome measurements for the injured worker. Given the above, the request for Omeprazole 20 mg # 30 refill 2 is not medically necessary.

Hydrocodone 5-325mg #120 Refill 0: Upheld

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

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

Decision rationale: The requested is not medically necessary. The California Medical Treatment Utilization Schedule (MTUS) Schedule (MTUS) Guidelines state that criteria for use

for ongoing management of opioids include ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. There was lack of evidence of opioid medication management and average pain, intensity of pain, or longevity of pain relief. The provider failed to submit urine drug screen indicating opioid compliance for the injured worker. There was lack of documentation of long term functional improvement for the injured worker. In addition, the request does not include the frequency or duration of medication. Given the above, the request for Hydrocodone 5/325 mg # 120 refill 0 is not medically necessary.

Voltaren 1% Gel: Upheld

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

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

Decision rationale: The request is not medically necessary. The California MTUS Guidelines state that Voltaren Gel 1% (Diclofenac) is recommended 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. The documents submitted lacked outcome measurements of medication management and home exercise regimen. In addition, the request lacked frequency, duration and location where the medication is supposed to be applied for the injured worker. Given the above, the request for Voltaren 1% is not medically necessary.