

Case Number:	CM14-0045943		
Date Assigned:	07/02/2014	Date of Injury:	01/10/2012
Decision Date:	08/27/2014	UR Denial Date:	03/21/2014
Priority:	Standard	Application Received:	04/14/2014

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 & Rehabilitation and is licensed to practice in Illinois. 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 48-year-old male who reported an injury on 01/10/2012 after an altercation with a student that grabbed his cell phone from his hand. No history provided. The diagnoses included right lateral epicondylitis, right medial epicondylitis with ulnar neuropathy at the elbow, right wrist sprain, bilateral moderate carpal tunnel syndrome, and right wrist internal derangement. The physical examination revealed lateral elbows tenderness to palpation, medial elbows tenderness to palpation, and a positive Tinel's at the elbow, the right wrist revealed 1st carpal metacarpal with tenderness to palpate, Tinel's sign and the Phalen's test were positive, grip strength and sensation reduced at the right wrist. The medications included ketoprofen 75 mg, omeprazole DR 20 mg, Medrox for pain, and capsaicin 1% cream. No VAS provided. Treatment plan included refill of medications. The Request for Authorization dated 11/12/2013 was submitted within documentation. No rationale was provided for the medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ketoprofen 75 mg once daily #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic pain Page(s): 72.

Decision rationale: The request for Ketoprofen 75 mg once a day is non-certified. Per the CA MTUS guidelines Ketoprofen is indicated for the use of osteoarthritis. Per the clinical notes the injured worker did not have a diagnosis of osteoarthritis. The request did not address the frequency. As such, the request is non-certified.

Omeprazole DR 20 mg once daily #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, pg. 68. Page(s): 68.

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

Decision rationale: The request for Omeprazole DR 20 mg once a day is not medically necessary. The California/ MTUS guidelines recommend the use of proton pump inhibitors if there is a history of gastrointestinal bleeding or perforations, a prescribed high dose of NSAIDs and a history of peptic ulcers. There is also a risk with long-term utilization of PPI (> 1 year) which has been shown to increase the risk of hip fracture. The clinical notes did not indicate that the injured worker had gastrointestinal bleeding, perforations or a history of peptic ulcers. The request did not address the frequency. As such, the request is not medically necessary.

Volteren 1% gel to be applied to affected area: Upheld

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

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

Decision rationale: The Voltaren 1% gel to be applied to the affected area is not medically necessary. 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). Per the chart notes provided there was no indication that the injured worker had arthritis. The request did not specify a location. The request not address the frequency. As such, the request is not medically necessary.