

Case Number:	CM14-0059845		
Date Assigned:	07/09/2014	Date of Injury:	05/01/2013
Decision Date:	08/28/2014	UR Denial Date:	04/15/2014
Priority:	Standard	Application Received:	04/30/2014

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 Occupational Medicine and is licensed to practice in California. 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 patient is a 40-year-old female with date of injury 05/01/2013. The medical document associated with the request for authorization, a primary treating physician's progress report, dated 03/26/2014, lists subjective complaints as pain in the left shoulder. Objective findings: Examination of the left shoulder revealed full cervical flexion, extension; lateral flexion and rotation reduced about 20% with facial grimacing and complaints of pain on the left side when moving to the right. Severe tenderness to palpation at the acromioclavicular joint and to a lesser degree at lateral acromion. Diagnosis includes left shoulder strain/sprain; sprain/strain, cervical; and sprain/strain, thoracic. Patient has completed 12 sessions of physical therapy to date. The medical records provided for review document that the patient has been taking the following medication for at least as far back as 6 months. Medications include Acetaminophen 500mg, #120, write on label (SIG): 1 four times per day (qid) as needed (prn); Gabapentin 600mg, #30 SIG: 1 at bedtime (qhs); Ibuprofen 800mg, #90 SIG: 1 twice a day (bid); and Prilosec, #30 SIG: at dinnertime.

IMR ISSUES, DECISIONS AND RATIONALES

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

Acetaminophen 500mg #120: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Acetaminophen (APAP).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Acetaminophen Page(s): 11.

Decision rationale: According to the MTUS, acetaminophen is recommended for treatment of chronic pain & acute exacerbations of chronic pain. There has been some discussion lately concerning the dose of acetaminophen, but it is recommended by the MTUS for acute and chronic pain except in those with liver disease. The request for Acetaminophen is medically necessary.

Gabapentin 600mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin (Neurontin).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Epilepsy Drug Page(s): 19.

Decision rationale: The MTUS states that gabapentin is an anti-epilepsy drug, which has been shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first-line treatment for neuropathic pain. An adequate trial period for gabapentin is three to eight weeks for titration, then one to two weeks at maximum tolerated dosage. With each office visit, the patient should be asked if there has been a change in the patient's pain symptoms, with the recommended change being at least 30%. There is no documentation of any functional improvement. Gabapentin is not medically necessary.

Ibuprofen 800mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-73.

Decision rationale: The MTUS recommend NSAIDs at the lowest dose for the shortest period in patients with moderate to severe pain. NSAIDs appear to be superior to acetaminophen, particularly for patients with moderate to severe pain. There is no evidence of long-term effectiveness for pain or function. Therefore, the request is not medically necessary.

Prilosec: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Proton Pump Inhibitor Page(s): 68.

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines and prior to starting the patient on a proton pump inhibitor, physicians are asked to evaluate the patient and to determine if the patient is at risk for gastrointestinal events. Criteria used are: (1) age greater than (>) 65 years; (2) history of peptic ulcer, gastrointestinal (GI) bleeding or perforation; (3) concurrent use of aspirin (ASA), corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID. There is no documentation that the patient has any of the risk factors needed to recommend the proton pump inhibitor omeprazole. Therefore, the request is not medically necessary.