

Case Number:	CM15-0086764		
Date Assigned:	05/11/2015	Date of Injury:	04/18/2014
Decision Date:	06/10/2015	UR Denial Date:	04/03/2015
Priority:	Standard	Application Received:	05/05/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Family Practice

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 43-year-old female, with a reported date of injury of 04/18/2014. The diagnoses include right wrist pain, right extensor carpi ulnaris tendonitis, and status post internal wrist repair on the right. Treatments to date have included an MRI of the right wrist joint on 07/07/2014 that showed partial tear of the triangular fibrocartilage complex; an x-ray of the right wrist; right wrist surgery; and oral pain medications. The medical report dated 03/17/2015 indicates that the injured worker had a tear of the cartilage repaired on 03/13/2015, and she presented with a soft cast on her arm. She was in a wrap and sling. The injured worker complained of significant right wrist pain. The physical examination showed no evidence of neurological loss into her fingers, signs of surgical prep, and right arm bundled in a soft tissue sling. She stated that she had swelling of her fingers, which was not uncommon after surgery. The treating physician requested Gabapentin 600mg #60 and Omeprazole 20mg #60. There was documentation that no more oxycodone or hydrocodone would be given, and the injured worker could not take non-steroidal anti-inflammatory drugs because of her systemic lupus erythematosus. On 04/03/2015, Utilization Review (UR) denied the request and noted that there was no indication that neuropathic type pain which would likely respond to anti-epileptics. In addition, the documentation did not support the need for proton pump inhibitory therapy, the documentation did not describe the injured worker's current gastrointestinal symptoms or treatment, and the documentation did not describe the injured worker's risk factors for GI bleed to justify prophylaxis.

IMR ISSUES, DECISIONS AND RATIONALES

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

Gabapentin 600mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines anti-epilepsy drugs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Epilepsy Drugs Page(s): 16-19.

Decision rationale: The MTUS/Chronic Pain Medical Treatment Guidelines comment on the use of anti-epilepsy drugs (AEDs), including gabapentin, as a treatment modality. AEDs are used for pain that is caused by a neuropathy. Examples of conditions for which AEDs are appropriate are as follows: Painful polyneuropathy: AEDs are recommended on a trial basis (gabapentin/pregabalin) as a first-line therapy for painful polyneuropathy (with diabetic polyneuropathy being the most common example). Postherpetic neuralgia: Gabapentin and pregabalin are recommended. Central pain: There are so few trials (with such small sample size) that treatment is generally based on that recommended for peripheral neuropathy, with gabapentin and pregabalin recommended. Chronic non-specific axial low back pain: A recent review has indicated that there is insufficient evidence to recommend for or against antiepileptic drugs for axial low back pain. In this case a review of the medical records does not provide any evidence that the cause of this patient's pain syndrome is from a neuropathy. Given the lack of evidence of a form of neuropathy as the cause of this patient's pain, there is no justification for the use of an AED. For this reason, Gabapentin is not a medically necessary treatment.

Omeprazole 20mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines non-steroidal anti-inflammatory drugs (NSAIDs) - Proton Pump Inhibitors (PPIs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, Gastrointestinal Symptoms and Cardiovascular Risk Page(s): 68-69.

Decision rationale: The MTUS/Chronic Pain Medical Treatment Guidelines comment on the use of proton pump inhibitors (PPIs), such as omeprazole, in patients with chronic pain. PPIs are typically indicated when a patient is on a long-term NSAID and is deemed to be at risk for a gastrointestinal event such as a GI bleed or an ulcer. The MTUS guidelines state the following: Clinicians should weight the indications for NSAIDs against both GI and cardiovascular risk factors. Determine if the patient is at risk for gastrointestinal events: (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low- dose ASA). Recommendations Patients with no risk factor and no cardiovascular disease: Non- selective NSAIDs OK (e.g, ibuprofen, naproxen, etc.) Patients at intermediate risk for gastrointestinal events and no cardiovascular disease: (1) A non-selective NSAID with either a PPI (Proton Pump Inhibitor, for example, 20 mg omeprazole daily) or misoprostol (200 g four times daily) or (2) a Cox-2 selective agent. Long-term PPI use (> 1 year) has been shown to increase the risk of hip fracture (adjusted odds ratio 1.44). Patients at high risk for gastrointestinal events with no cardiovascular disease: A Cox-2 selective agent plus a PPI if absolutely necessary. Patients at high risk of gastrointestinal events with cardiovascular disease: If GI risk is high the suggestion

is for a low-dose Cox-2 plus low dose Aspirin (for cardioprotection) and a PPI. If cardiovascular risk is greater than GI risk the suggestion is naproxyn plus low-dose aspirin plus a PPI. In this case, there is no evidence that this patient is at intermediate or high-risk of a significant gastrointestinal event. There are no diagnoses provided in the medical records to indicate that the patient has any of the above cited risk factors. For this reason, the use of Omeprazole is not medically necessary.