

Case Number:	CM14-0120100		
Date Assigned:	09/16/2014	Date of Injury:	08/13/2012
Decision Date:	10/27/2014	UR Denial Date:	07/11/2014
Priority:	Standard	Application Received:	07/30/2014

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 Internal 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 injured worker is 42 year-old female who is reported to have sustained cumulative trauma injuries to the right upper extremities on 08/13/12. She has chronic complaints of right shoulder pain. She is status post a right shoulder rotator cuff repair on 02/08/13 with revision on 11/01/13. A right carpal tunnel release was performed on this same date. On examination of the right shoulder there is restricted range of motion, positive Neer's and Hawkin's signs. On examination of the right wrist there is tenderness of the volar and ulnar aspects, and decreased sensation in the index and middle fingers. The record contains a UDS dated 06/27/14 which was inconsistent with injured workers medication profile. The injured worker reports a VAS of 7/10 without medications and 5/10 with. The record contains a utilization review determination dated 07/11/14 in which requests for Hydrocodone 5/500mg # 30, Butalbital/APAP/Caffeine #30, Celebrex 200 mg #30, and Omeprazole 20 mg # 30 were non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

30 Tablets of Hydrocodone Bitartrate/APAP 5/500mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Barbituate-containing analgesic agents(BCAs) Page(s): 23.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opiates Page(s): 74-80.

Decision rationale: The request for hydrocodone 5/500mg #30 is not supported as medically necessary. The submitted clinical records indicate the injured worker has chronic right upper extremity pain. She is status post rotator cuff repair with revision. Typically opiate medications are stopped after the rehabilitation period. The injured worker has not returned to work and there is no documentation of functional improvements as a result of this medication. It further appears that there is compliance issue based on the 06/27/14 UDS result. As such the request does not meet California Medical Treatment Utilization Schedule for continued use and medical necessity is not established.

30 Tablets of Butalbital/APAP/Caffeine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Barbiturate-containing analgesic agents(BCAs) Page(s): 23.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Barbiturate-containing analgesic agents (BCAs) Page(s): 23.

Decision rationale: The request for Butalbital/APAP/Caffeine # 30 is not supported as medically necessary. California Medical Treatment Utilization Schedule does not recommend this medication for chronic pain. The potential for drug dependence is high and no evidence exists to show a clinically important enhancement of analgesic efficacy of BCAs due to the barbiturate constituents. (McLean, 2000) There is a risk of medication overuse as well as rebound headache. (Friedman, 1987). As such, the medical necessity for this medication is not established.

30 Capsules of Celebrex 200mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs(non-steroidal anti-inflammatory drugs) Page(s): 67-68.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Celebrex Page(s): 30.

Decision rationale: The request for Celebrex 200 mg # 30 is not medically necessary. The submitted clinical records do not indicate the injured worker has failed other NSAID's or is NSAID intolerant. As such, the medical necessity for the continued use of this medication is not established.

30 Capsules of Omeprazole 20mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI symptoms & cardiovascular risk Page(s): 67-68.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Proton Pump Inhibitor

Decision rationale: The request for Omeprazole 20 mg # 30 is not supported as medically necessary. The record does not indicate that the injured worker suffers from medication induced gastritis. As such the continued use of this medication is not medically necessary.