

Case Number:	CM14-0185554		
Date Assigned:	11/13/2014	Date of Injury:	11/18/2011
Decision Date:	12/19/2014	UR Denial Date:	10/28/2014
Priority:	Standard	Application Received:	11/07/2014

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 Anesthesiology and is licensed to practice in Tennessee, North Carolina, and Georgia. 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 37-year-old female who reported an injury on 11/18/2011. The mechanism of injury was not submitted for review. The injured worker has diagnoses of disorder of bursae and tendons in shoulder region, pain in joint involving shoulder, pain in joint involving upper arm, mononeuritis unspecified site, insomnia, complex regional pain syndrome, and osteoarthritis (localized, not specified whether primary or secondary). Past medical treatment consists of psychotherapy, cognitive behavioral therapy, physical therapy, spinal cord stimulator, medication therapy, H-wave unit, stellate ganglion blocks, and acupuncture. Medications consist of pantoprazole, topical analgesia (flurbiprofen/lidocaine), Lyrica, and Celebrex. No urinalyses (UAs) or drug screens were submitted for review. On 10/09/2014, the injured worker complained of right shoulder and right arm pain. It was noted on physical examination that the injured worker rated the pain at a 6/10 to 9/10. Physical examination revealed that the right arm had pain and decreased movement. It was also documented on examination that there was more localized pain in the cervical spine. There was decreased range of motion, and the pain was reproducible in the neck and arm with movement. There were components of allodynia throughout her right arm. Her wrist was edematous with minimal range of motion. There was constant paresthesia. Medical treatment plan was for the injured worker to continue with medication therapy. The rationale and Request for Authorization form were not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Pantoprazole 20 mg, sixty count,: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter

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

Decision rationale: The request for Pantoprazole 20 mg, sixty count, is not medically necessary. The California MTUS Chronic Pain Guidelines state that proton pump inhibitors may be recommended to treat dyspepsia secondary to non-steroidal anti-inflammatory drug (NSAID) therapy. The addition of proton pump inhibitors is also supported for patients taking NSAIDs and some medications who have cardiovascular disease or significant risk factors for gastrointestinal events. There was no indication in the submitted documentation of the injured worker having taken any NSAID therapy. Additionally, there was no documentation indicating that the injured worker had complaints of dyspepsia, cardiovascular disease, or significant risk factors for gastrointestinal events. In the absence of this documentation, the request is not supported by the evidence based guidelines. Furthermore, the request as submitted failed to indicate the frequency and duration of the medication. As such, the request is not medically necessary.

Flurbiprofen 20%/Lidocaine 5%, 200 count,: Upheld

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

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

Decision rationale: The request for flurbiprofen 20%/lidocaine 5%, 200 count, is not medically necessary. California MTUS Guidelines state that transdermal compounds are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least 1 drug that is not recommended is not recommended. The guidelines also state that Lidoderm patch is the only topical form of lidocaine approved. The submitted documentation lacked the efficacy of the medication and did not indicate that the medication was helping with any functional deficits. Additionally, there was no inclination of the injured worker being unresponsive or intolerant to other treatments. The guidelines do not recommend topical lidocaine in any form other than Lidoderm patch. Furthermore, there was no evidence submitted for review indicating that the injured worker had failed a trial of antidepressants or anticonvulsants. Given the above, the injured worker is not within the recommended guideline criteria. As such, the request is not medically necessary.

