

Case Number:	CM15-0008958		
Date Assigned:	02/10/2015	Date of Injury:	12/06/2012
Decision Date:	06/03/2015	UR Denial Date:	12/22/2014
Priority:	Standard	Application Received:	01/15/2015

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, Washington

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 44 year old male, who sustained an industrial injury on 12/6/2012. Diagnoses include cervical and lumbar sprain/strain, bilateral shoulder impingement with partial rotator cuff tears, right lateral epicondylitis, right knee sprain and left knee sprain. Treatments to date include intra-articular injections, left shoulder arthroscopy with debridement and rotator cuff repair and medication management. A progress note from the treating provider dated 11/10/2014 indicates the injured worker reported left shoulder and knee pain. The injured worker reported constant pain aggravated by squatting, kneeling, ascending and descending stairs, walking multiple blocks, and prolonged standing. The injured worker also admitted to mild swelling and buckling. The injured worker reported constant left shoulder pain aggravated by reaching, lifting, pushing, pulling, or working. Upon examination of the knee, there was a positive patellar grind test, tenderness at the joint line, positive McMurray's sign, crepitus with painful range of motion, and negative instability. Examination of the left shoulder revealed mild stiffness secondary to immobilization and limited range of motion with weakness. Treatment recommendations included continuation of the current medication regimen, and the home exercise program. It was also noted the injured worker was pending authorization for a left knee arthroscopy. A Request for Authorization form was submitted on 12/08/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Omeprazole 20mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms and Cardiovascular Risk.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68-69.

Decision rationale: California MTUS Guidelines state, proton pump inhibitors are recommended for patients at intermediate or high risk for gastrointestinal events. Patients with no risk factor and no cardiovascular disease do not require the use of a proton pump inhibitor, even in addition to a nonselective NSAID. In this case, there was no documentation of cardiovascular disease or increased risk factors for gastrointestinal events. The medical necessity for the requested medication has not been established. Additionally, there is no frequency listed in the request. As such, the request is not medically appropriate.

Ondansetron 8mg #30: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: The Official Disability Guidelines do not recommend ondansetron for nausea and vomiting secondary to chronic opioid use. It has been FDA approved for nausea and vomiting secondary to chemotherapy and radiation treatment. It is also FDA approved for acute gastroenteritis. The injured worker does not maintain a diagnosis of acute gastroenteritis. The medical necessity for the use of this medication has not been established. There is also no frequency listed in the request. As such, the request is not medically necessary at this time.

Cyclobenzaprine 7.5mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants for Pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63-66.

Decision rationale: California MTUS Guidelines state muscle relaxants are recommended as non-sedating second line options for short-term treatment of acute exacerbations. Cyclobenzaprine should not be used for longer than 2 to 3 weeks. In this case, there is no evidence of palpable muscle spasm or spasticity upon examination. The medical necessity for the requested medication has not been established. The guidelines do not support long-term use

of this medication. There is also no frequency listed in the request. As such, the request is not medically necessary.

Eszopiclone 1mg #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Insomnia Treatment.

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

Decision rationale: The Official Disability Guidelines recommend insomnia treatment based on etiology. Lunesta has demonstrated reduced sleep latency and sleep maintenance. The injured worker does not maintain a diagnosis of insomnia disorder. The medical necessity for the requested medication has not been established. There was also no documentation of an attempt at non-pharmacologic treatment. There was also no frequency listed in the request. As such, the request is not medically necessary.