

Case Number:	CM15-0010811		
Date Assigned:	02/02/2015	Date of Injury:	07/01/2009
Decision Date:	03/27/2015	UR Denial Date:	01/08/2015
Priority:	Standard	Application Received:	01/20/2015

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, Arizona

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 72-year-old male who reported an injury on 07/01/2009. The mechanism of injury was not provided. He is diagnosed with myofascial pain syndrome and repetitive strain syndrome. Current medications include Naprosyn, Omeprazole, Neurontin, and Mentherm gel. Diagnoses also included right wrist strain and left elbow strain. Surgical history, and other therapies were not provided. The progress note on 12/15/2014 noted the injured worker continued to have pain in the bilateral arms and some numbness of the right hand. The injured worker is doing a home exercise program once or twice a week. He takes his medicine but noted that naproxen was not effective. Upon examination of the right wrist and right elbow, there was tenderness. There was decreased range of motion of the left elbow. The Request for Authorization was not provided within the documentation submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective DOS 12/15/2014: 100 Tablets of Neurontin 600mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drug (AEDs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepileptic Drugs Page(s): 16, 17.

Decision rationale: The request for Retrospective DOS 12/15/2014: 100 Tablets of Neurontin 600mg is not supported. The California MTUS guidelines recommend antiepilepsy medications as a first line medication for treatment of neuropathic pain. There should be documentation of an objective decrease in pain of at least 30% to 50% and objective functional improvement. There is a lack of documentation as to the frequency the medication needs to be used. As such, the request is not medically necessary.

Retrospective DOS 12/15/2014: 1 Month supply of Voltaren XR 100mg: Upheld

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

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

Decision rationale: The request for Retrospective DOS 12/15/2014: 1 Month supply of Voltaren XR 100mg is not supported. The California Medical Treatment Utilization Schedule Guidelines indicate that NSAIDS are recommended for short term symptomatic relief of low back pain. It is generally recommended that the lowest effective dose be used for all NSAIDS for the shortest duration of time consistent with the individual patient treatment goals. There should be documentation of objective functional improvement and an objective decrease in pain. There is a lack of documentation as to the body part for which the cream is to be used. There is a lack of documentation as to the frequency the cream is to be used. As such, the request is not medically necessary.

Retrospective DOS 12/15/2014: 100 Capsules of Omeprazole 20mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Chapter, Proton pump inhibitors (PPIs)

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

Decision rationale: The request for Retrospective DOS 12/15/2014: 100 Capsules of Omeprazole 20mg is not supported. The California Medical Treatment Utilization Schedule 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. Therefore, the injured worker does not currently meet criteria for the requested medication. There is a lack of documentation of the frequency the medication is to be used. There is a lack of documentation that the injured worker has GI issues. As such, the request is not medically necessary.