

Case Number:	CM15-0013208		
Date Assigned:	01/30/2015	Date of Injury:	04/12/2011
Decision Date:	03/30/2015	UR Denial Date:	01/02/2015
Priority:	Standard	Application Received:	01/22/2015

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 62-year-old male who reported an injury on 04/12/2011. The mechanism of injury was not provided. His diagnoses include left ankle osteochondritis dissecans defect, bilateral plantar fasciitis, and right ankle pain. Medications included diclofenac XR 100 mg and omeprazole 20 mg. On 12/02/2014, the injured worker was seen for pain at a level of 3/10. Upon examination of the left ankle/foot there was a positive antalgic gait. The injured worker was ambulating with a cane. There was positive tenderness over the plantar fascia. There was positive tenderness over the anterior talofibular ligament. There was positive pain with plantar flexion and inversion. Upon examination of the right ankle/foot there was positive tenderness over the plantar fascia. There was positive pain with plantar flexion and inversion. The treatment plan included obtaining authorization for left knee arthroscopy, microfracture, and possible OATS procedure. The injured worker is indicated for Functional Capacity Assessment to determine accurate impairment rating. The request is for retrospective diclofenac XR 100 mg #60 DOS: 12/02/2014 and retrospective request for omeprazole 20 mg #60 DOS: 10/02/2014. 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 request for Diclofenac XR 100mg #60 DOS: 12/02/14: Upheld

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

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

Decision rationale: The retrospective request for diclofenac XR 100 mg #60 DOS: 12/02/2014 is not medically necessary. 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 of the frequency within the request. The request is not supported. As such, the request is not medically necessary.

Retrospective request for Omeprazole 20mg #60 DOS: 12/02/14: Upheld

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

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

Decision rationale: The retrospective request for omeprazole 20 mg #60 DOS: 12/02/2014 is not medically necessary. 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 also no strength, frequency or quantity listed in the request. There is lack of documentation of the frequency within the request. The request is not supported. As such, the request is not medically necessary.