

Case Number:	CM15-0035587		
Date Assigned:	04/01/2015	Date of Injury:	02/01/2007
Decision Date:	05/13/2015	UR Denial Date:	01/26/2015
Priority:	Standard	Application Received:	02/25/2015

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

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 71-year-old female who reported an injury on 02/01/2007 due to cumulative trauma while performing normal job duties. The injured worker reportedly sustained an injury to her bilateral upper extremities. The injured worker's chronic pain was controlled with medications to include Lidoderm patches, topical ketamine, ondansetron, pantoprazole, docusate, Lidoderm, diclofenac sodium and gabapentin. The injured worker's diagnoses included degenerative changes of the cervical spine, carpal tunnel syndrome, pain in the hand joint and pain in upper arm joints. The injured worker was evaluated on 10/22/2014. Physical findings included restricted range of motion of the lumbar spine with no significant deficits of the upper extremities. It was noted that the injured worker had been using a TENS unit in conjunction with medications to reduce pain. It was noted that the injured worker reported Zofran was helpful in relieving intermittent nausea. It was also noted that the injured worker complained of GI upset that was controlled with the use of Protonix. It was noted that the injured worker was able to walk better with less pain and perform activities of daily living to include light cleaning and dishes with the use of medications. At that appointment, the injured worker's treatment plan included continuation of medications. No Request for Authorization was submitted to support the request.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retro (DOS 10/30/14) Pantoprazole - Protonix QTY 60: 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) Treatment in Workers Compensation (TWC); Proton Pump Inhibitors (PPI), Pain Procedure Summary.

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

Decision rationale: The retrospective request for date of service 10/30/2014 for Pantoprazole/Protonix, quantity 60 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends gastrointestinal protectants for patients who are at risk for developing gastrointestinal events related to medication usage. The clinical documentation does indicate that the injured worker complains of GI upset that is well controlled with the use of Protonix. However, this is a retrospective request for date of service 10/30/2014. No documentation from the date of service was provided. Therefore, ongoing use of this medication is not supported. Furthermore, the request as it is submitted does not clearly identify a dosage or frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested retrospective request for date of service 10/30/2014 for Pantoprazole/Protonix, quantity 60 is not medically necessary or appropriate.

Retro (DOS 10/30/14): Ondansetron - Zofran 4mg QTY 60: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Mosby's Drug Consult: Zofran (Ondansetron).

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, Anti-emetics.

Decision rationale: The retrospective request for date of service 10/30/2014, Ondansetron/Zofran 4 mg quantity 60 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not address this medication. Official Disability Guidelines recommend the use of this medication for acute gastritis or postsurgical nausea. The clinical documentation submitted for review does indicate that the injured worker experiences intermittent nausea that is well controlled with this medication. However, this is a retrospective request for 10/30/2014. No clinical documentation submitted from the date of service was provided. Therefore, ongoing use of this medication in this clinical situation is not supported. As such, the requested retrospective request for date of service 10/30/2014, Ondansetron/Zofran 4 mg quantity 60 is not medically necessary or appropriate.

Retro (DOS 10/30/14): Lidoderm 5% Patch (700mg/patch) QTY 60: 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): 111-112.

Decision rationale: The requested Lidoderm 5% patch 700 mg/patch, quantity 60 for date of service 10/30/2014 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends the ongoing use of a Lidoderm patch be supported by documented functional benefit and evidence of pain relief. The clinical documentation submitted for review does indicate that the injured worker has increased function related to the use of this medication. However, an objective measurement of pain relief was not provided. Furthermore, this is a retrospective request for 10/30/2014. There was no clinical documentation submitted for review from the requested date of service. Therefore, ongoing use of this medication would not be supported. As such, the retrospective request for date of service 10/30/2014 Lidoderm 5% patch 700 mg/patch is not medically necessary or appropriate.

Retro (DOS 10/30/14): Diclofenac Sodium 1.5% 60gm: 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) Treatment in Workers Compensation (TWC); Pain Procedure Summary lasted updated 12/31/14.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112.

Decision rationale: The retrospective request for date of service 10/30/2014 for diclofenac, sodium 1.5% 60 gm is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does recommend the short-term use of nonsteroidal anti-inflammatory drugs in the management of chronic pain related to the upper extremities. However, continued use should be supported by documented functional benefit and evidence of pain relief. The clinical documentation submitted for review does indicate that the injured worker has functional benefit from the use of the requested medications. However, there is no documentation that the patient has adequate pain relief resulting from this medication. No quantifiable assessment of pain relief was provided. Furthermore, this is a retrospective request from 10/30/2014. There was no documentation submitted from the requested date of service. Therefore, ongoing use of this medication would not be supported. As such, the retrospective request for date of service 10/30/2014, diclofenac sodium 1.5% 60 gm is not medically necessary or appropriate.

Retro (DOS 09/19/14): Pantoprazole - Protonix 20mg #60: 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) Treatment in Workers Compensation (TWC); Proton Pump Inhibitors (PPI), Pain Procedure Summary.

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

Decision rationale: The retrospective request for date of service 09/19/2014 for Pantoprazole/Protonix, 20 mg #60 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends the ongoing use of gastrointestinal protectants for patients who are at risk for developing gastrointestinal events related to medication usage. The clinical documentation submitted for review does indicate that the injured worker complains of GI upset related to medication usage that is well controlled with of Protonix. However, this is a retrospective request for 09/19/2014. There is no documentation submitted for review from the date of service. Therefore, ongoing use of this medication is would not be supported in this clinical situation. Furthermore, the request as it is submitted does not clearly identify a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Pantoprazole/Protonix 20 mg #60 is not medically necessary or appropriate.

Retro (DOS 9/19/14): Ondansetron - Zofran 4mg #60: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Mosby's Drug Consult: Zofran (Ondansetron).

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, Anti-emetics.

Decision rationale: The retrospective request for date of service 09/19/2014, Ondansetron/Zofran 4 mg quantity 60 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not address this medication. Official Disability Guidelines recommend the use of this medication for acute gastritis or postsurgical nausea. The clinical documentation submitted for review does indicate that the injured worker experiences intermittent nausea that is well controlled with this medication. However, this is a retrospective request for 09/19/2014. No clinical documentation submitted from the date of service was provided. Therefore, ongoing use of this medication in this clinical situation is not supported. As such, the requested retrospective request for date of service 09/19/2014, Ondansetron/Zofran 4 mg quantity 60 is not medically necessary or appropriate.

Retro (DOS 9/19/14):Lidoderm 5% Patch (700mg/patch): 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): 111-112.

Decision rationale: The requested Lidoderm 5% patch 700 mg/patch, quantity 60 for date of service 09/19/2014 is not medically necessary or appropriate. California Medical Treatment

Utilization Schedule recommends the ongoing use of a Lidoderm patch be supported by documented functional benefit and evidence of pain relief. The clinical documentation submitted for review does indicate that the injured worker has increased function related to the use of this medication. However, an objective measurement of pain relief was not provided. Furthermore, this is a retrospective request for 09/19/2014. There was no clinical documentation submitted for review from the requested date of service. Therefore, ongoing use of this medication would not be supported. As such, the retrospective request for date of service 09/19/2014 Lidoderm 5% patch 700 mg/patch is not medically necessary or appropriate.

Retro (DOS 9/19/14): Diclofenac Sodium 1.5mg 60gm: 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) Treatment in Workers Compensation (TWC); Pain Procedure Summary lasted updated 12/31/14.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112.

Decision rationale: The retrospective request for date of service 09/19/2014 for diclofenac, sodium 1.5% 60 gm is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does recommend the short-term use of nonsteroidal anti-inflammatory drugs in the management of chronic pain related to the upper extremities. However, continued use should be supported by documented functional benefit and evidence of pain relief. The clinical documentation submitted for review does indicate that the injured worker has functional benefit from the use of the requested medications. However, there is no documentation that the patient has adequate pain relief resulting from this medication. No quantifiable assessment of pain relief was provided. Furthermore, this is a retrospective request from 09/19/2014. There was no documentation submitted from the requested date of service. Therefore, ongoing use of this medication would not be supported. As such, the retrospective request for date of service 09/19/2014, diclofenac sodium 1.5% 60 gm is not medically necessary or appropriate.