

<b>Case Number:</b>	CM15-0060873		
<b>Date Assigned:</b>	04/07/2015	<b>Date of Injury:</b>	12/02/1999
<b>Decision Date:</b>	06/01/2015	<b>UR Denial Date:</b>	03/02/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/31/2015

### 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: Preventive Medicine, Occupational Medicine, Public Health & General Preventive Medicine

### 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 64 year old male with an industrial injury dated 12/02/1999. The mechanism of injury was a slip and fall. His diagnosis includes neck pain and shoulder pain. Medical history included coronary stents and coronary artery bypass graft times 3. Prior treatment includes treatment for infection of injured area, medications and surgeries. He presents on 02/09/2015 for a recheck on neck, shoulder and elbow pain. He was scheduled for surgery on 02/11/2015 for left lateral elbow bone debridement. With the exception of vital signs a physical exam is not documented for this visit. The treating physician documents the injured worker needs medication refills. The treatment plan was for refill of his medications and for the scheduled surgery.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Nexium 40 mg #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms, and cardiovascular risk. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)-pain.

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

**Decision rationale:** The California MTUS Guidelines recommend proton pump inhibitors for injured workers at intermediate risk or higher for gastrointestinal events and are also for the treatment of dyspepsia secondary to NSAID therapy. The clinical documentation submitted for review failed to indicate the injured worker had signs or symptoms of dyspepsia. However, the injured worker did have a history of a coronary artery procedure. This medication would be supported. However, the efficacy was not provided. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Nexium 40 mg #90 is not medically necessary.

**Celebrex 200 mg #180:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-63.

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

**Decision rationale:** The California MTUS Guidelines indicate that NSAIDS are recommended for short-term symptomatic relief of mild to moderate pain. There should be documentation of objective functional improvement and an objective decrease in pain. The clinical documentation submitted for review failed to provide documentation of objective functional improvement and an objective decrease in pain with the use of the medication. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Celebrex 200 mg #180 is not medically necessary.

**Voltaren 1% Gel #6:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines topical analgesics Page(s): 111-113.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Voltaren Gel Page(s): 112.

**Decision rationale:** The California Medical Treatment Utilization Schedule Guidelines indicate that Voltaren Gel 1% (diclofenac) is an FDA approved agent indicated for relief of osteoarthritis pain in joints that lends themselves to topical treatment such as the ankle, elbow, foot, hand, knee, and wrist. It has not been evaluated for treatment of the spine, hip or shoulder. Maximum dose should not exceed 32 g per day (8 g per joint per day in the upper extremity and 16 g per joint per day in the lower extremity). The clinical documentation submitted for review failed to provide the efficacy for the requested medication. There was a lack of documentation indicating the injured worker had osteoarthritis. The request as submitted failed to indicate the frequency and the body part to be treated. There was a lack of documentation indicating a necessity for 6

tubes of Voltaren gel. Given the above, the request for Voltaren 1% gel #6 is not medically necessary.

**Hydrocortisone cream 2.5% #9: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines topical analgesics Page(s): 111-113.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation [www.drugs.com/mtm/hydrocortisone-topical.html](http://www.drugs.com/mtm/hydrocortisone-topical.html).

**Decision rationale:** Per Drugs.com, Hydrocortisone topical is used to treat inflammation of the skin caused by a number of conditions such as allergic reactions, eczema, or psoriasis. The clinical documentation submitted for review failed to provide the rationale for the requested medication. The request as submitted failed to indicate the body part and the frequency to be treated. There was a lack of documented rationale indicating a necessity for 9 tubes of hydrocortisone. Given the above, the request for hydrocortisone cream 2.5% #9 is not medically necessary.

**EpiPen 0.3 mg/0.3ml 2 pack #1: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation FDA guidelines-EpiPen.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) [www.drugs.com/epipen-auto-injector.html](http://www.drugs.com/epipen-auto-injector.html).

**Decision rationale:** Per Drugs.com, EpiPen is used to treat severe allergic reactions to insect stings or bites, foods, drugs, and other allergens. The clinical documentation submitted for review failed to provide documentation of a rationale for the requested EpiPen. Additionally, the request as submitted failed to indicate the frequency for the request. Given the above, the request for EpiPen 0.3 mg/0.3 ml 2 pack #1 is not medically necessary.