MAXIMUS Federal Services

Case Number:	CM13-0007529		
Date Assigned:	09/05/2013	Date of Injury:	11/02/2009
Decision Date:	06/10/2014	UR Denial Date:	07/26/2013
Priority:	Standard	Application Received:	08/05/2013

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. The expert reviewer is Board Certified in Occupataional Medicine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

Patient is a 63 year-old female with date of injury 11/02/2009. The medical record associated with the request for authorization, a primary treating physician's progress report, dated 7/22/2013, lists subjective complaints as constant dull pain with radicular symptoms in the cervical spine, thoracic spine and right wrist. Patient states that the pain is sharp sometimes and is also associated with occasional numbness. Objective findings: Examination of the cervical and thoracic spine and right wrist revealed decreased range of motion. Cervical compression, Soto-Hall test SCM test on the right and Kemp's test were all positive. Pinwheel evaluation revealed patient had hyperesthesia of the right C5-T1 dermatomes. Diagnosis: 1. Cervical spine strain/sprain 2. Right wrist strain/sprain 3. Thoracic spine sprain/strain 4. Brachial neuritis/radiculitis 6. Myalgia/Mytosis. At the time of evaluation, physician stated that the patient had improved range of motion, reduced pain, increased grip strength, and decreased objective signs of radiculopathy. Patient has completed 6 physical therapy sessions to date. There is documentation in the medical records provided for review that the patient has been prescribed the medications requested below since at least October 2012.

IMR ISSUES, DECISIONS AND RATIONALES

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

RETROSPECTIVE OMEPRAZOLE 20MG #60 WITH A DOS 7/22/2013: Upheld

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

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

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines and prior to starting the patient on a proton pump inhibitor, physicians are asked to evaluate the patient and to determine if the patient is at risk for gastrointestinal events. Criteria used are: (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID. There is no documentation that the patient has any of the risk factors needed to recommend the proton pump inhibitor OMEPRAZOLE 20MG #60 FOR DOS 7/22/2013. The request is not medically necessary.

RETROSPECTIVE TEROCIN LOTION WITH DOS 7/22/2013: Upheld

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

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

Decision rationale: According to the MTUS, compounds containing lidocaine are not recommended for non-neuropathic pain. There is only one trial that tested 4% lidocaine for treatment of chronic muscle pain. The results showed there was no superiority over placebo. The patient's physical exam shows no evidence of radiculopathy or neuropathic pain. The retrospective request for terocin lotion is not medically necessary.

RETROSPECTIVE DENDRACIN LOTION WITH DOS 7/22/2013: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 28 and 105.

Decision rationale: Dendracin Lotion is a topical analgesic with the active ingredients, methyl salicylate 30%, capsaicin 0.0375%, and menthol USP 10% used for the temporary relief of mild pain due to muscular strain, arthritis, and simple back pain. Capsaicin topical is recommended only as an option in patients who have not responded or are intolerant to other treatments. The medical record contains no documentation that the patient is intolerant of unresponsive to other treatments. The retrospective request for dendracin lotion is not medically necessary.

RETROSPECTIVE SYNOVACIN GLUCOSAMINE SULFATE 500MG #90 WITH DOS 7/22/2013: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 50.

Decision rationale: Recommended as an option given its low risk, in patients with moderate arthritis pain, especially for knee osteoarthritis. Studies have demonstrated a highly significant efficacy for crystalline glucosamine sulphate (GS) on all outcomes, including joint space narrowing, pain, mobility, safety, and response to treatment, but similar studies are lacking for glucosamine hydrochloride (GH). Glucosamine is recommended for osteoarthritis of the knee. The patient does not have this diagnosis. The retrospective request for Synovacin glucosamine sulfate 500mg #90 is not medically necessary.

RETROSPECTIVE TRAMADOL ER 150MG #30 WITH DOS 7/22/2013: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioid Section.

Decision rationale: The Chronic Pain Medical Treatment Guidelines state that continued or long-term use of opioids should be based on documented pain relief and functional improvement or improved quality of life. Tramadol is a centrally acting synthetic opioid analgesic and it is not recommended as a first-line oral analgesic. There is no documentation of functional improvement supporting the continued long-term use of opioids. The retrospective request for tramadol er 150mg #30 is not medically necessary.

RETROSPECTIVE TENS ELECTRODES WITH DOS 7/22/2013: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-117.

Decision rationale: It appears from the medical record that the patient has been using a TENS unit since at least 08/20/2012, but there is no documentation since that time that a TENS unit has improved the patient's functional capacity. Due to the lack of documentation of functional improvement, TENS electrodes are not medically necessary.