

Case Number:	CM13-0015610		
Date Assigned:	10/08/2013	Date of Injury:	11/19/2012
Decision Date:	07/21/2014	UR Denial Date:	08/12/2013
Priority:	Standard	Application Received:	08/22/2013

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 Physical Medicine and Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Texas. 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:

The injured worker is a 54 year old female who had a work related injury on 11/19/12, the injured worker was carrying a roll of plastic at the end of her shift, she slipped and fell on her buttocks, both feet were up in the air, the roll she was carrying weighed about 30 pounds, landed on her right hand and injured her right wrist. The injured worker felt immediate pain in her right wrist. X-rays showed comminuted fracture of right wrist was given injection in her wrist, fracture was reduced and a splint was applied to her wrist. She then had a cast reapplied to her wrist. Once the cast was removed the patient had carpal tunnel syndrome and underwent wrist surgery in 06/13, carpal tunnel release followed by four to six sessions of physical therapy which she stated was not beneficial. The most recent progress note dated 11/12/13 the patient was complaining of neck pain, right shoulder pain, right wrist pain. Physical examination of cervical spine showed decreased range of motion, especially right lateral bending, and flexion/extension with right rotation. Positive cervical compression, positive maximal foraminal compression on the right, positive Hoffman on the right, mildly on the left, loss of sensation C5 nerve root distribution on the right. Grip strength markedly decreased. MRI was significant for 4.5mm disc herniation C5-6 with reversal of cervical lordosis. Right shoulder examination marked loss of range of motion with pain and crepitus elicited upon active and passive range of motion. Positive apprehension test, Hawkins test, Neers test. MRI consistent with adhesive capsulitis. Right wrist loss of grip strength, numbness in hands. Diagnoses was cervical intervertebral disc displacement without myelopathy. C5-6 radiculopathy on the right. Adhesive capsulitis right shoulder, secondary to impingement. CRPS right upper extremity secondary to comminuted fracture. Request was for retrospective prescription for Dyotin SR 250mg two tablets twice daily and theraflex cream apply thin layer three times per day, and Biotherm lotion apply thin layer two- three times per day. Prior utilization review on 08/12/13 was non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

RETROSPECTIVE REQUEST FOR PRESCRIPTION OF DYOTIN SR 250MG, 2 TABLETS TWICE DAILY.: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Epilepsy Drugs (AEDS) Page(s): 16-17.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs Page(s): 16-22. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Gabapentin.

Decision rationale: The submitted documentation does not support the request for Dyotin (gabapentin). The injured worker had fracture of her right wrist, developed carpal tunnel syndrome (CTS), had a carpal tunnel release, and now has developed complex regional pain syndrome (CRPS). The submitted clinical documentation, does not note any functional improvement on gabapentin. The request for Dyotin SR 250 mg is not medically necessary.

RETROSPECTIVE REQUEST FOR PRESCRIPTION OF THERAFLEX CREAM, APPLY THIN LAYER 2-3 TIMES PER DAY: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Application Page(s): 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Herbal Medicines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesic Page(s): 111. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Topical Analgesics.

Decision rationale: The clinical documentation submitted for review does not support the request. There is no documentation of functional improvement submitted, to continue using the theraflex cream. The request for retrospective for prescription of Theraflex Cream is not medically necessary.

RETROSPECTIVE REQUEST FOR PRESCRIPTION OF BIO-THERM LOTION, APPLY THIN LAYER 2-3 TIMES PER DAY: 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), Pain Chapter, Herbal Medicines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, topical analgesics.

Decision rationale: Compounded medication is considered experimental, any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The use of compounded agents requires knowledge of the specific analgesic effect of each agent and how it will be useful for the specific therapeutic goal required. The request for retrospective prescription for Bio-therm lotion is not medically necessary.