

| | | | |
|-----------------------|--------------|------------------------------|------------|
| Case Number: | CM13-0037324 | | |
| Date Assigned: | 12/13/2013 | Date of Injury: | 06/25/2013 |
| Decision Date: | 02/03/2014 | UR Denial Date: | 09/19/2013 |
| Priority: | Standard | Application Received: | 09/30/2013 |

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Anesthesiology, has a subspecialty in Pain Management 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 physician 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 patient is a 49 year old male who reported an injury on 06/25/2013 after getting the patient's hand smashed by a cart. The patient underwent x-rays that did not reveal any fractures. The patient was initially treated conservatively with hot/cold packs, an Ace bandage, and medications. The patient also underwent physical therapy. The patient underwent electrodiagnostic testing that revealed right moderate compression of the medial nerve at the carpal tunnel with a normal EMG. The patient's medications included cyclobenzaprine 7.5 mg, tramadol 150 mg, naproxen sodium 550 mg, ondansetron ODT 4 mg, pantoprazole 20 mg, and Ortho-Nesic gel. The patient's most recent clinical examination findings included complaints of sharp right wrist pain and numbness of the right hand and fingers rated at 7/10. Physical findings included 3+ tenderness to palpation of the dorsal wrist, Phalen's test causing pain, and decreased median nerve distribution sensation. The patient's diagnoses included right carpal tunnel syndrome and right wrist sprain/strain. The patient's treatment plan included acupuncture and continued physical therapy with an MRI and electrodiagnostic studies.

IMR ISSUES, DECISIONS AND RATIONALES

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

Pantoprazole 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).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 60, 68.

Decision rationale: The requested pantoprazole 20 mg #60 is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient has continued pain of the right wrist and forearm. It is also noted the patient has been on a non-steroidal anti-inflammatory drug for this pain. California Medical Treatment Utilization Schedule recommends the use of a gastrointestinal protectant such as pantoprazole for patients on high doses of non-steroidal anti-inflammatory drugs that are at risk for gastrointestinal events. The clinical documentation submitted for review does not provide any evidence that the patient is at high risk for gastrointestinal events or that the patient is taking high doses of non-steroidal anti-inflammatory drugs. As such, the requested pantoprazole 20 mg #60 is not medically necessary or appropriate.

Ortho-nesic gel: 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, Topical Agents.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications Section Chronic Pain and Topical Analgesics Page(s): 60, 111.

Decision rationale: The requested Ortho-Nesic gel is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient has persistent right wrist and forearm complaints. California Medical Treatment Utilization Schedule does not recommend the use of topical analgesics. They are not supported by scientific evidence to support the efficacy and safety of these types of medications. The requested medication Ortho-Nesic gel does contain menthol and camphor. California Medical Treatment Utilization Schedule recommends medications that are used in the management of chronic pain be supported by functional benefit and symptom response. The clinical documentation submitted for review does not provide any evidence that this medication is providing functional benefit or symptom relief for this patient. As such, the requested Ortho-Nesic gel is not medically necessary or appropriate.

Ondansetron ODT 4mg #30: 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, Anti-emetics.

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 requested ondansetron ODT 4 mg #30 is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient has chronic and persistent right wrist and forearm pain complaints. Official Disability Guidelines do not recommend the use of antiemetics to control symptoms related to medication intake. Additionally, this medication is FDA-approved for acute exacerbations of gastroenteritis. The clinical documentation submitted for review does not provide any evidence that the patient is experiencing an acute exacerbation of gastroenteritis. Additionally, there was no documentation of ongoing nausea and vomiting that would need medical intervention. As such, the requested ondansetron ODT 4 mg #30 is not medically necessary or appropriate.