

Case Number:	CM13-0037493		
Date Assigned:	12/13/2013	Date of Injury:	03/31/2013
Decision Date:	06/13/2014	UR Denial Date:	10/15/2013
Priority:	Standard	Application Received:	10/23/2013

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 Family Medicine and is licensed to practice in Arizona. 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 patient is a 49 year old female with a date of injury on 03/31/2013. Diagnoses include comminuted right middle phalanx fracture, finger pain, arm pain, and myofascial pain syndrome. She also has a history of hypertension and gastritis from taking non-steroidal anti-inflammatory medication. Subjective complaints are of pain in the right upper extremity that was achy and worse at night. It is also indicated that the medications the patient was using, along with the use of a TENS unit, helped to reduce her pain from a 9/10 to a 6-7/10. Objective findings included mild swelling of the right fifth digit; no warmth or signs of infection; tenderness to palpation and the distal phalanx was stuck in a slightly flexed position with no range of motion. The proximal phalanx had a range of motion of 5°; the metacarpophalangeal joint had a normal range of motion; right grip strength was 4/5; left grip strength was 5/5; bilateral wrist, elbow and shoulder ranges were within normal limits; arm strength was 5/5 bilaterally; mild tenderness was elicited on palpation of the right antecubital fossa and the front of the right shoulder. Medications include Anaprox 550mg twice a day, ketoprofen cream, and Prilosec. Prior treatments include TENS, acupuncture, and physical therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

NAPROXEN SODIUM 550MG, 60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-69.

Decision rationale: The CA MTUS recommends NSAIDS at the lowest effective dose in patients with moderate to severe pain. Furthermore, NSAIDS are recommended as an option for short-term symptomatic relief for back pain. Precautions are given for hypertensive patients, and patients with history of GI problems. For this patient, there is a history of hypertension and NSAID induced gastritis. Therefore, the request Naproxen would be contraindicated for this patient, and is not medically necessary.

OMEPRAZOLE 20MG, 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs and GI Risk..

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs and GI Risk, Page(s): 68.

Decision rationale: According to CA MTUS guidelines, a proton pump inhibitor can be added to NSAID therapy if the patient is at an intermediate to high risk for adverse GI events. Guidelines identify the following as risk factors for GI events: age >65, history of peptic ulcer, GI bleeding or perforation, use of ASA, corticosteroids, anticoagulant use, or high dose NSAIDs. This patient has a history of NSAIDs induced gastritis. Since NSAIDs are not recommended for this patient, subsequently a proton pump inhibitor for GI prophylaxis is also not recommended. Therefore, the medical necessity of omeprazole is not established.

LIDO 3%, 2 PRESCRIPTIONS: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm, Page(s): 56.

Decision rationale: The CA MTUS recommends Lidoderm as a second line treatment for localized peripheral pain after there has been evidence of first line therapy treatment failure. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than post-herpetic neuralgia. The submitted documentation does not provide evidence for post-herpetic neuralgia or for localized peripheral pain. Furthermore, lidocaine is only recommended as a dermal patch. No other commercially approved topical formulations of lidocaine are indicated. Therefore, the medical necessity of 3% lidocaine is not established.