

Case Number:	CM13-0059183		
Date Assigned:	12/30/2013	Date of Injury:	06/20/2007
Decision Date:	04/03/2014	UR Denial Date:	11/07/2013
Priority:	Standard	Application Received:	12/01/2013

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 Physical Medicine and Rehabilitation, has a subspecialty in Pain Management 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 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 52-year-old female who reported an injury on 06/20/2007, after a slip and fall. The patient's treatment history included medications, physical therapy, activity modifications, surgical intervention, and steroid injections. The patient's most recent clinical documentation noted that the patient had a restricted range of motion of the cervical spine secondary to pain, restricted range of motion of the lumbar spine secondary to pain, with a negative straight leg raising test bilaterally. Evaluation of the bilateral wrists documented mild tenderness to palpation over the dorsal and volar wrists and a negative Tinel's sign bilaterally. Evaluation of the bilateral elbows and forearms documented that the patient had a negative Tinel's sign and tenderness along the lateral aspect of the elbow with full range of motion. The patient's diagnoses included right wrist contusion with significant strain, left wrist and hand contusion with residual chronic left wrist pain, bilateral lateral epicondylitis, lumbosacral contusion with strain, cervical strain with persistent symptoms, and bilateral shoulder strain with persistent symptoms. The patient's treatment plan included chiropractic care, referral to a hand surgeon, and continuation of medications to include naproxen, tramadol, Pennsaid, Biofreeze, Sombra cream, and omeprazole.

IMR ISSUES, DECISIONS AND RATIONALES

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

Naproxen Sodium 550mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 46. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic pain and NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 60 and 67.

Decision rationale: The requested naproxen sodium 550 mg is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does recommend the use of nonsteroidal anti-inflammatory drugs in the management of a patient's chronic pain. However, the California Medical Treatment Utilization Schedule recommends documentation of functional benefit and an assessment of pain relief to support continued use of medications used in the management of chronic pain. The clinical documentation submitted for review does not provide any evidence of functional increases or documented pain relief as a result of the use of this medication. Therefore, continued use would not be supported. As such, the requested naproxen sodium 550mg is not medically necessary or appropriate.

Tramadol 50mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Knee Complaints, Tramadol(Ultram).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-Going Management Page(s): 78.

Decision rationale: The requested tramadol 50 mg is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends the continued use of opioids in the management of chronic pain be supported by a quantitative assessment of pain relief, managed side effects, documentation of functional benefit, and evidence that the patient is monitored for aberrant behavior. The clinical documentation submitted for review does not provide any evidence that the patient is monitored for aberrant behavior. Additionally, there is no documentation of functional benefit or a quantitative assessment to support pain relief related to medication usage. Therefore, continued use of this medication is not supported. As such, the requested tramadol 50 mg is not medically necessary or appropriate.

Pennsaid 1.3%: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111,112-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

Decision rationale: The requested Pennsaid 1.3% is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends limited use of nonsteroidal anti-inflammatory drugs as topical agents. The use of these types of medications should be

limited to patients who are not able to tolerate oral formulations, or when oral formulations are contraindicated to the patient. The clinical documentation submitted for review does not provide any evidence that the patient is not able to tolerate oral formulations of nonsteroidal anti-inflammatory drugs. Therefore, continued use of this medication would not be supported. As such, the requested Pennsaid 1.3% is not medically necessary or appropriate.

Biofreeze 6 oz jar: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation www.drugs.com/otc/113018/pain-relieving.html

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

Decision rationale: The requested Biofreeze 6 ounce jar is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does support the use of this type of medication for patients with osteoarthritic pain. The clinical documentation submitted for review does not provide any evidence that the patient's pain is osteoarthritic in nature. Therefore, the need for this medication is not indicated. As such, the requested Biofreeze 6 ounce jar is not medically necessary or appropriate.

Omeprazole Capsul 20mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68. Decision based on Non-MTUS Citation (ODG), Pain Chapter

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

Decision rationale: The requested omeprazole capsule 20 mg is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends the use of gastrointestinal protectants for patients who are at risk for developing gastrointestinal disturbances related to medication usage. The clinical documentation submitted for review does not provide an adequate assessment of the patient's gastrointestinal system to support that the patient is at risk for developing gastrointestinal disturbances related to medication usage. Therefore, continued use of this medication would not be indicated. As such, the requested omeprazole capsule 20 mg is not medically necessary or appropriate.