

Case Number:	CM13-0060587		
Date Assigned:	12/30/2013	Date of Injury:	02/21/2013
Decision Date:	04/03/2014	UR Denial Date:	11/12/2013
Priority:	Standard	Application Received:	12/03/2013

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 Interventional Spine 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 60-year-old injured worker with a date of injury of 02/21/2013. The listed diagnoses per [REDACTED] are: (1) History of crush injury involving the right forearm and wrist with ulnar distal diaphyseal fracture and complex wounds of the forearm and wrist, (2) Status post wound exploration with repair immobilization of distal ulnar fracture dated 02/22/2010, (3) Post-injury residual wrist and forearm tenosynovitis with distal radioulnar joint incongruity. According to report dated 10/28/2013 by [REDACTED], the patient presents with persistent ulnar-sided right wrist pain. The patient notes some poor motion in her wrist with associated weakness. It was noted the patient was unable to continue Voltaren due to some mild dyspepsia. Upon examination, the patient presented with mild dorsal wrist and distal forearm swelling. There was tenderness noted over the distal radioulnar joint and some non focal tenderness that extends over the dorsal aspect of the wrist. A mild attenuation in active extension of the wrist is noted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Protonix 20mg #60: Overturned

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

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

Decision rationale: The MTUS Chronic Pain Medical Treatment Guidelines page 69 states, "Omeprazole is recommended with precautions as indicated below. Clinicians should weigh the indications for NSAIDs against both GI and cardiovascular risk factors. Determine if the patient is at risk for gastrointestinal events: (1) Ages over 65 years, (2) History of peptic ulcer, GI bleeding or perforation, (3) Congruent use of ASA, corticosteroids, and/or anticoagulant, or (4) high dose/multiple NSAIDs." The medical records provided for review indicate that the patient presents with persistent ulnar sided right wrist pain. Furthermore, the patient had some dyspepsia with Voltaren and current prophylactic use of a PPI is consistent with the guidelines. The request for Protonix 20mg # 60 is medically necessary and appropriate.

Naprosyn 500mg #60: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 22.

Decision rationale: For anti-inflammatory medications, the MTUS Guidelines page 22 states, "Anti-inflammatory are the traditional first line of treatment to reduce pain, so activity and functional restoration can resume, but long term use may not be warranted." Reports dated 10/28/2013 states patient is unable to take Voltaren due to some "mild dyspepsia" and is prescribed a trial of Naprosyn. The patient presents with persistent ulnar-sided right wrist pain and is not noted to be on any other pain medication. Given patient's continued complaints of pain, Naprosyn is supported. The request for Naprosyn 500mg, #60 is medically necessary and appropriate.

Muscle stim unit: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 112.

Decision rationale: The MTUS Guidelines page 112 states neuromuscular electrical stimulation (NMES devices) are not recommended. "NMES is use primarily as part of a rehabilitation program following a stroke, and there is no evidence to support use in chronic pain. There is no intervention trial suggesting benefit from NMES for chronic pain or postsurgical care." This patient is not part of a rehabilitation program following a stroke. The request for a muscle stim unit is not medically necessary and appropriate.