

Case Number:	CM13-0067472		
Date Assigned:	03/21/2014	Date of Injury:	01/03/2012
Decision Date:	05/27/2014	UR Denial Date:	11/21/2013
Priority:	Standard	Application Received:	12/17/2013

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 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 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 51 year old female who was injured on 01/03/2012 when she slipped and fell while pushing a cart for disposal. Prior treatment history has included physical therapy, medications, and was placed on modified work; physiotherapy. The patient underwent a mid line lumbar epidural steroid injection at L5-S1 under fluoroscopy, epidurogram on 12/12/2012. Diagnostic studies reviewed include electrodiagnostic consultation dated 08/01/2013. MRI of the right wrist dated 07/09/2013 revealed negative ulnar variance with distal radioulnar and radio carpal degenerative; there is slight widening of the scapholunate interval, raising question for scapholunate ligamentous instability; and a small intercarpal effusion and synovitis is suggested. MRI of the left shoulder dated 07/09/2013 revealed mild rotator cuff tendinosis with down sloping acromion and acromioclavicular joint degenerative change without full-thickness tear or retraction; and SLAP lesion is seen extending to but not avulsing the biceps. MRI of the left hip dated 07/09/2013 revealed probable heterogeneous fibroid uterus is partially evaluated; and spurring, bilateral hips, with degenerative disk disease, lumbar spine but without acute osseous, labral, tendinous, or muscular signal abnormality. MRI of the left wrist dated 07/09/2013 demonstrated a negative ulnar variance with degenerative change, distal radioulnar joint and first carp metacarpal joint; probable small volar radio carpal synovial/ganglion cyst; and no evidence for acuter TFCC, ligamentous or tendinous abnormality. X-ray of the lumbar spine with bending dated 06/10/2013 demonstrated mild degenerative changes, prior right upper quadrant abdomen surgery, and otherwise normal images of the lumbar spine. MRI of the cervical spine dated 01/05/2013 showed a 1-2 mm posterior disc bulges at C5-C6 and C6-C7 without evidence of canal stenosis or neural foraminal narrowing. PR2 dated 09/16/2013 reports the patient with a complaint of bilateral wrist and hand, left elbow, and left hip complaints which she rates a 2-7/10 on the pain scale. Per the patient, she is about the same. She continues to have pain with

walking and rates her left hip pain today as a 7/10 on the pain scale and her wrist pain a 2-3/10 on the pain scale, along with the shoulder to 3/10 on a pain scale. Left shoulder examination revealed flexion from 0 to 160 degrees; abduction 0 to 160 degrees, external rotation 0 to 80 degrees, internal rotation 0 to 70 degrees; adduction and extension 0 to 50 degrees; positive pain in the AC joint with direct palpation; Positive pain in the AC joint with cross-arm testing; negative Speed's test; negative drop arm test; positive subacromial bursitis, positive impingement; negative apprehension test; negative O'Brien's test; sensation intact to the C5 distribution to light touch; 4+/5 strength in flexion, abduction; external rotation; internal rotation; adduction and extension. Left hip examination revealed flexion 0 to 130 degrees, extension 0 to 30 degrees; internal rotation 0 to 30 degrees; external rotation 0 to 50 degrees, adduction 0 to 30 degrees; There is no instability about the left hip; positive tenderness over the trochanteric bursa; positive FABER test, positive Gaenslen's test, positive distraction test, positive compression test. There is no pain in groin with internal, external or any other range of motion of the hip. There are no signs of infection about the hip. Left wrist/hand examination revealed extension 0 to 70 degrees; flexion 0 to 70 degrees, radial deviation 0 to 20 degrees; ulnar deviation 0 to 40 degrees; negative Phalen's; positive Tinel's; positive carpal compression test with 2+ radial pulse; negative Finkelstein's; negative CMC grind test. There is no triggering of any fingers or thumb of the hand. There is no sign of infection or CRPS. There is tenderness over the flexor tendons of the wrist and grip strength is 4+/5. There is full range of motion of MCP and IP joints.

QME dated 05/08/2013 reports a diagnosis of 1) Low back pain 2) Multilevel disc disease 3) Suspected left-sided radiculopathy 4) Normal neck exam 5) Abnormal gait with the use of a cane. He states the patient is either confused, or slow, or not paying attention. She had great difficulty dealing with my exam and answering questions. In regards to future medical care, the patient would probably benefit from repeat epidural steroid injections. If this does not cause relief, consider consultation with a neurosurgeon. Prior to any surgery, this patient should be evaluated. It seems that the patient has not benefited from conservative care and needs to go the next level of care. On review of records, note dated 08/15/2013 indicates a denial for treatment, including x-rays, MRI's, chiropractic treatment and follow-up. It states, reliability for treatment. It goes on to explain the injuries to the lumbar spine only; injuries to the bilateral wrists and hands, left shoulder and left hip are denied.

IMR ISSUES, DECISIONS AND RATIONALES

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

KETOPROFEN 20% CREAM: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: According to the CA MTUS guidelines, Ketoprofen is not currently FDA approved for a topical application. It has an extremely high incidence of photo-contact dermatitis. Only FDA approved are recommended. As per the guidelines, any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The request for Ketocream is not recommended under the guidelines, and as such, the medical necessity of this request is not established.

NORCO 7.5/325MG #40: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96.

Decision rationale: According to CA MTUS, Hydrocodone/Acetaminophen (Anexsia®; Co-Gesic®; Hycet®; Lorcet®; Lortab®; Margesic-H®; Maxidone®; Norco®, Stagesic®, Vicodin®, Xodol®, Zydone®; generics available) is indicated for moderate to moderately severe pain. It is classified as short-acting opioids, which are seen as an effective method in controlling chronic pain. They are often used for intermittent or breakthrough pain. These agents are often combined with other analgesics such as acetaminophen and aspirin. Guidelines indicate "four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids; pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or no adherent) drug-related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors)." The medical records do not indicate this medication is appropriate for this patient. The medical records do not demonstrate the patient has had sustained improved pain level and increased function with chronic opioid use. There is no mention regular re-assessment of non-opioid means of pain control. Given the reported subjective pain level and objective findings non-opioid pharmacologic means of analgesia would be appropriate, and effective in improving moderate to moderately severe pain. The medical necessity of Norco is not established.

OMEPRAZOLE 20MG #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines GI Symptoms and Cardiovascular Risk Page(s): 68-69.

Decision rationale: The medical records reviewed do not document any gastrointestinal complaints. The CA MTUS guidelines state medications such as Prilosec may be indicated for patients at risk for gastrointestinal events, which are: 1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA). However, none of the above listed criteria apply to this patient. The guidelines recommend GI protection for patients with specific risk factors; however, the medical records do not establish the patient is at significant risk for GI events. Consequently, Omeprazole is not medically necessary.