

Case Number:	CM14-0000517		
Date Assigned:	01/10/2014	Date of Injury:	01/07/2007
Decision Date:	07/11/2014	UR Denial Date:	12/02/2013
Priority:	Standard	Application Received:	01/02/2014

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 Internal 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 56 year old male who was injured on 01/07/2007 while he was trying to reach out over the phone, he felt a pop with pain along his right dorsal medial wrist area. Prior treatment history has included Ecotrin low strength 81 mg, Oxycodone 10 mg, Lipitor 20 mg, aspirin 81 mg, Cymbalta 30 mg, Tylenol Codeine #3 300/30 mg. On 10/17/2013, the patient started 6 sessions of physical therapy. PR2 dated 12/20/2013 documented the patient has pain in the right styloid area. He rated his pain as 7-8/10. He denied any recent trauma, falls, or other activity. Also the patient has complaints of pain along the dorsum of his right hand and wrist that varies from 7-8/10 with any motion of the right wrist. The pain radiates to the elbow and up to the right shoulder. Objective findings on exam revealed 2+ tenderness to palpation on the dorsum of the right wrist along the TFCC, 1+ radial aspect first dorsal compartment. There is no swelling noted. He has limited range of motion of the right wrist. There is no erythema. Bilateral upper extremity strength is normal. Phalen's test on the left is positive and Tinel's is positive on the left. The patient is diagnosed with traumatic epicondylitis, tenosynovitis hand/wrist, joint disease nonspecific of the upper arm. The patient is instructed on a home exercise program and also instructed to continue to use DME supplies, wrist support, and gel ice pack. He is instructed to continue with his medications. Prior UR dated 12/02/2013 states the request for unknown physical therapy is non-certified as it is unclear how many visits are being requested. Tramadol is non-certified as the dosage is not stated in the request and Opioid coverage is non-certified as specific treatment, medication, and dosage amount are not stated in the request.

IMR ISSUES, DECISIONS AND RATIONALES

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

UNKNOWN PHYSICAL THERAPY: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines PHYSICAL MEDICINE Page(s): 98-99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

Decision rationale: The CA MTUS guidelines recommend physical therapy for musculoskeletal injuries as part of initial conservative therapy. The patient has previously undergone therapy for 6 visits. However, there was insufficient documentation to discuss the results of the physical therapy. The request for unknown physical therapy does not specify the intended body area to treat with therapy, indication, or number of visits. Further information including subjective/objective findings along with treatment plan is necessary. Based on the guidelines and criteria as well as the clinical documentation stated above, the request is not medically necessary.

PRESCRIPTION FOR TRIAL TRAMADOL: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS Page(s): 75-94.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 75-94.

Decision rationale: The CA MTUS recommends chronic opioid therapy for pain when specific criteria are met, including improved analgesia, no adverse effects, no aberrant behavior, improved ADLs. The notes document the patient has been on oxycodone and it is unclear why a request is being made to either switch opioid therapy or for dual opioid therapy. The request did not contain a dose, frequency, or number of tablets to dispense. Further clinical information should be provided which address all criteria above to justify the use of ongoing opioid therapy for musculoskeletal pain. Based on the guidelines and criteria as well as the clinical documentation stated above, the request is not medically necessary.

UNKNOWN OPIOID COVERAGE: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS Page(s): 75-94.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 75-94.

Decision rationale: The CA MTUS recommends chronic opioid therapy for pain when specific criteria are met, including improved analgesia, no adverse effects, no aberrant behavior,

improved ADLs. The notes document the patient has been on oxycodone and it is unclear which opioid is being requested. The request does not contain a specific medication, dose, frequency, or number of tablets to dispense. Further clinical information should be provided which address all criteria above to justify the use of ongoing opioid therapy for musculoskeletal pain. Based on the guidelines and criteria as well as the clinical documentation stated above, the request is not medically necessary.