

Case Number:	CM14-0018612		
Date Assigned:	04/18/2014	Date of Injury:	04/10/2001
Decision Date:	07/02/2014	UR Denial Date:	01/23/2014
Priority:	Standard	Application Received:	02/13/2014

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 Physical Medicine and Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Texas and Ohio. 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 injured worker is a 58 year old female who reported an injury on 04/10/2001. The mechanism of injury was not provided in the clinical documentation. The injured worker reports numbness and tingling to bilateral upper extremities. The injured worker reports pain at 8/10 to bilateral wrists, neck and low back. Per the clinical note dated 03/27/2014 the injured worker had increased difficulty with activities of daily living. The injured worker has decreased range of motion to bilateral upper extremities and positive tinels to bilateral wrists. The diagnoses reported for the injured worker were cervical and lumbar radiculopathy, bilateral carpal tunnel syndrome and bilateral tendonitis of the shoulders. The request for authorization for medical treatment was dated 01/23/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

PHYSICAL THERAPY, #8: 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 Chronic Pain Medical Treatment Guidelines state that active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy may require supervision from a therapist or medical provider such as verbal, visual and/or tactile instruction(s). Injured workers should participate in an active self-directed home physical medicine program. The guidelines recommend 9-10 visits over 8 weeks for myalgia and myositis, unspecified and 8-10 visits over 4 weeks for neuralgia, neuritis, and radiculitis, unspecified. There is a lack of documentation regarding current deficits, functional benefit from prior physical therapy or the completed sessions to date. Additionally, there is a lack of documentation regarding any prior physical therapy or home physical therapy program. The requesting physician did not include an adequate and complete assessment of the injured workers range of motion and the efficacy of the prior therapy was not demonstrated within the provided documentation. Therefore, the request for 8 sessions of physical therapy is not medically necessary.

SOMA 350MG, #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 65.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CARISOPRODOL (SOMA) Page(s): 29.

Decision rationale: The Chronic Pain Medical Treatment Guidelines do not recommend this medication for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. Carisoprodol is a commonly prescribed, centrally acting skeletal muscle relaxant. There is a lack of documentation regarding the length of time the injured worker has already taken this medication and the efficacy of the medication. There is high potential for dependence and therefore Soma is recommended for short term use only. Therefore, the request for Soma 350mg, #120 is not medically necessary.

PRILOSEC 20MG, #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 68.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI SYMPTOMS AND CARDIOVASCULAR RISK Page(s): 68.

Decision rationale: The Chronic Pain Medical Treatment Guidelines note because of the risk of side effects and long term problems, the use of proton pump inhibitors is limited to those individuals greater than 65 years of age, those with a history of peptic ulcer, GI bleed or perforation, and those on high doses or multiple NSAIDS. Long-term PPI use, 1 year, has been shown to increase the risk of hip fracture. The documentation provided indicated the injured worker used NSAIDS as needed. There was a lack of documentation of the strength of the

NSAIDS taken as well as the frequency. There was also a lack of documentation indicating the injured worker has any of the conditions required for use of a proton pump inhibitor and is at risk for gastrointestinal events. Therefore, the request for Omeprazole 20mg #30 is not medically necessary.

TEROCIN OINTMENT: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 28-29, 112-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL ANALGESICS Page(s): 111-112.

Decision rationale: Chronic Pain Medical Treatment Guidelines state that topical NSAIDS are recommended for short-term treatment of osteoarthritis and tendinitis affecting joints that are amenable to topical treatment, but this does not include the spine, shoulders or hips. Capsaicin is recommended only as an option in patients who have not responded or are intolerant to other treatments. Lidocaine, in any form other than Lidoderm patch, is not indicated for neuropathic pain. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Therefore, as this is a compounded topical, Terocin lotion is not medically necessary.