

Case Number:	CM14-0162518		
Date Assigned:	10/07/2014	Date of Injury:	12/04/2013
Decision Date:	11/20/2014	UR Denial Date:	09/22/2014
Priority:	Standard	Application Received:	10/02/2014

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 Occupational 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:

This case involves a 32-year-old male with a 12/4/13 date of injury. He injured his right hand between his index and first digit when he was passing plywood to a coworker. According to a progress report dated 9/15/14, the patient complained of right shoulder pain rated 7.5/10 with tingling and numbness. There was a hot sensation noted on the right second digit. The patient also reported that walking helped with bloating. He denied any gastrointestinal side effects. On physical examination, there was a 1 by 1 cm cyst on the second digit and there was decreased finger flexion. There was tenderness on palpation on the right shoulder and improved range of motion of 160/180 degrees. Diagnostic impression: status post injury of right hand, right shoulder sprain/strain, and status post right hand surgery (12/2013). Treatment to date includes medication management, activity modification, exercise, and TENS. A UR decision dated 9/22/14, denied the requests for Naproxen, Omeprazole, and Menthoderm. There is no documentation of significant pain reduction, change in Visual Analog Scale (VAS) score, or objective examples of functional improvement noted with the continued use of the requested medications. Topical agents are largely experimental in use with few randomized controlled trials to determine efficacy or safety.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective Naproxen 550mg #60 (DOS: 9/15/14): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Epilepsy Drugs Page(s): 16-17, 21.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.24.2 NSAIDS Page(s): 67. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, NSAIDS

Decision rationale: CA MTUS states that non-steroidal anti-inflammatory drugs (NSAIDs) are effective, although they can cause gastrointestinal irritation or ulceration or, less commonly, renal or allergic problems. Studies have shown that when NSAIDs are used for more than a few weeks, they can retard or impair bone, muscle, and connective tissue healing and perhaps cause hypertension. In addition, Official Disability Guidelines (ODG), states that there is inconsistent evidence for the use of these medications to treat long-term neuropathic pain, but they may be useful to treat breakthrough pain. However, in the present case, there is no documentation of significant pain relief or functional gains from the use of this NSAID. Guidelines do not support the ongoing use of NSAID medications without documentation of functional improvement. Therefore, the request for retrospective Naproxen 550mg #60 (DOS: 9/15/14) was not medically necessary.

Retrospective Omeprazole 20mg #60 (DOS: 9/15/14): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI Symptoms and Cardiovascular Risk Page(s): 68. Decision based on Non-MTUS Citation Food and Drug Administration (FDA), (Omeprazole)

Decision rationale: CA MTUS and the FDA support proton pump inhibitors (PPI) in the treatment of patients with gastrointestinal (GI) disorders such as; gastric/duodenal ulcers, GERD, erosive esophagitis, or patients utilizing chronic non-steroidal anti-inflammatory drugs (NSAIDs) therapy. Omeprazole is a proton pump inhibitor used in treating reflux esophagitis and peptic ulcer disease. There is no comment that relates the need for the proton pump inhibitor for treating gastric symptoms associated with the medications used in treating this industrial injury. In general, the use of a PPI should be limited to the recognized indications and used at the lowest dose for the shortest possible amount of time. However, in the present case, because the initial request for the NSAID was not found to be medically necessary, this associated request for GI prophylaxis from NSAID use cannot be substantiated. In addition, it is noted that the patient denied any gastrointestinal side effects. Therefore, the request for retrospective Omeprazole 20mg #60 (DOS: 9/15/14) was not medically necessary.

Retrospective Menthoderm 120gm #1 (DOS: 9/15/14): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 67-68, 73.

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

Decision rationale: CA MTUS states that topical salicylates are significantly better than placebo in chronic pain. However, while the guidelines referenced support the topical use of mental salicylates, the requested Mentherm has the same formulation of over-the-counter products such as BenGay. It has not been established that there is any necessity for this specific brand name. A specific rationale identifying why Mentherm is required instead of an equivalent over-the-counter formulation was not provided. Therefore, the request for retrospective Mentherm 120gm #1 (DOS: 9/15/14) was not medically necessary.