

Case Number:	CM14-0022589		
Date Assigned:	06/11/2014	Date of Injury:	05/15/2011
Decision Date:	07/21/2014	UR Denial Date:	02/17/2014
Priority:	Standard	Application Received:	02/24/2014

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 & Rehabilitation and is licensed to practice in Illinois. 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 49-year-old female who reported an injury on 05/15/2011 due to a cumulative trauma while performing normal job duties. The injured worker reportedly sustained an injury to her left upper extremity. The injured worker's treatment history included physical therapy, multiple medications, a TENS unit, H-wave therapy, and acupuncture. The injured worker was evaluated on 04/04/2013. It was documented that the injured worker had a positive impingement sign and adduction test of the left shoulder with positive tenderness to the acromioclavicular joint. The injured worker had positive Tinel's and Phalen's signs to the left wrist and decreased sensation of the left-sided digits of the hand. The injured worker's medications included naproxen 550 mg, Prilosec 20 mg, Terocin lotion 120 mL, and tramadol extended release 150 mg. The injured worker's diagnoses included pain in the left shoulder, numbness and tingling in the bilateral hands, and pain in the bilateral wrists. The injured worker's treatment plan included continuation of medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

RETROSPECTIVE 04/04/2013 OMEPRAZOLE 20MG #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms & Cardiovascular Risk Page(s): 68.

Decision rationale: The retrospective request for omeprazole 20 mg #60 for 04/04/2013 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends this type of medication for patients who are at risk for developing gastrointestinal events related to medication usage. The clinical documentation from 04/04/2013 does not adequately evaluate the injured worker's gastrointestinal system to support that they are at risk for development of gastrointestinal events related to medication usage. Therefore, the ongoing use of this medication would not be supported. Furthermore, the request as it is submitted does not clearly define a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested omeprazole 20 mg #60 is not medically necessary or appropriate.

RETROSPECTIVE 04/04/2013 TEROGIN 120ML: Upheld

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

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

Decision rationale: The retrospective request for Terocin 120 mL on 04/04/2013 is not medically necessary or appropriate. The requested medication is a compounded topical analgesic that contains menthol, methyl salicylate, capsaicin, and lidocaine cream. California Medical Treatment Utilization Schedule does support the use of menthol and methyl salicylate in the management of chronic pain. However, California Medical Treatment Utilization Schedule does not support the use of capsaicin as a topical analgesic unless there is documentation that the injured worker has failed to respond to first line chronic pain management treatments. The clinical documentation submitted for review fails to provide any evidence that the patient has failed to respond to first line medications to include anticonvulsants and antidepressants. Therefore, the use of capsaicin as a topical analgesic would not be supported. Additionally, California Medical Treatment Utilization Schedule does not recommend the use of lidocaine in a cream or gel formulation, as it is not FDA approved to treat neuropathic pain. Furthermore, the request as it is submitted does not provide a frequency or an appropriate body part. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the retrospective request for Terocin cream 120 mL on 04/04/2013 is not medically necessary or appropriate.

RETROSPECTIVE 04/04/2013 TRAMADOL/HYDROCHLORIDE 150MG #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-Going Management.

Decision rationale: The requested tramadol/hydrochloride 150 mg #30 from date of service 04/04/2013 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends ongoing use of opioids is supported by documentation of functional benefit, a quantitative assessment of pain relief, managed side effects, and evidence that the injured worker is monitored for aberrant behavior. The clinical documentation from 04/04/2013 fails to provide any evidence that the injured worker has any pain relief or functional benefit resulting from medication usage. Additionally, the clinical documentation submitted for review does not provide any evidence that the injured worker is monitored for aberrant behavior. Therefore, ongoing use of an opioid medication would not be supported. Furthermore, the request as it is submitted does not provide a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the retrospective request for 04/04/2013 for tramadol/hydrochloride 150 mg #30 is not medically necessary or appropriate.

RETROSPECTIVE 04/04/2013 RANGE OF MOTION TESTING X 2: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, Wrist and Hand, Computerized Muscle Testing.

Decision rationale: The retrospective request for 04/04/2013 range of motion testing x 2 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not specifically address this request. Official Disability Guidelines do not recommend computerized muscle testing of the forearm, wrists, or hands, as there are no scientific studies to support the need for this type of testing over what can be provided from a traditional physical evaluation. There are no exceptional factors noted within the documentation to support extending treatment beyond guideline recommendations. As such, the retrospective request from 04/04/2013 for range of motion testing x 2 is not medically necessary or appropriate.