

Case Number:	CM14-0030452		
Date Assigned:	06/20/2014	Date of Injury:	06/27/2006
Decision Date:	07/17/2014	UR Denial Date:	02/07/2014
Priority:	Standard	Application Received:	03/10/2014

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 and is licensed to practice in Texas and Oklahoma. 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 50-year-old female who reported an injury on 06/27/2006. The mechanism of injury was not provided within the documentation. The injured worker was noted to have prior treatments of medication and home exercise. The objective findings included ongoing tenderness to both wrists, more on the left and bilateral weak grips. The injured worker was noted to have diagnoses of chronic left wrist pain status post neurolysis of radial nerve left distal forearm, release of the first extensor compartment in 12/2007. A triple phase bone scan showed an abnormality in the left ulnar styloid. There was subtle abnormalities at the metacarpophalangeal joint, index fingers suggest mild arthritic changes or inflammation at this location. The treatment plan included medications: Ultram, Prilosec, Ambien, Zanaflex, and Phenergan. In addition, a prescription was provided for Percocet. The injured worker was encouraged to remain active and return for a followup visit in 3 months. The request for authorization for medical treatment was dated 01/31/2014. The provider did not indicate a rationale for the request.

IMR ISSUES, DECISIONS AND RATIONALES

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

Prilosec 20 mg, QTY: 90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS (Non-Steroidal Anti-Inflammatory Drugs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI symptoms and cardiovascular risk Page(s): 68.

Decision rationale: The request for Prilosec 20 mg quantity 90 is not medically necessary. The Chronic Pain Medical Treatment Guidelines indicate clinicians should weigh the indications for NSAIDs against both gastrointestinal and cardiovascular risk factors. The Guidelines stated the patient may be at risk for gastrointestinal events when age is greater than 65 years; history of peptic ulcer; gastrointestinal bleeding or perforation; concurrent use of aspirin, corticosteroids, and/or anticoagulant; or high dose/multiple NSAID use. The Guidelines indicate if a patient is at intermediate risk for gastrointestinal events and no cardiovascular disease: a nonselective NSAID with either a proton-pump inhibitor, for example, 20 mg omeprazole daily or misoprostol 200 mg 4 times daily or COX-2 selective agent. Long term proton-pump inhibitor use greater than 1 year has been shown to increase the risk of hip fracture. According to the clinical evaluation on 01/23/2014 the injured worker is not noted to have an intermediate or high risk for gastrointestinal events. The use of Prilosec is not noted to provide efficacy in the documentation submitted. The provider's rationale for the requested medication was not provided within the documentation. A frequency for the Prilosec medication is not provided within the request. Therefore, the request for Prilosec 20 mg quantity 90 is not medically necessary.

Ambien 5 mg, QTY: 90: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain (chronic).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Zolpidem.

Decision rationale: The request for Ambien 5 mg quantity 90 is not medically necessary. The Official Disability Guidelines indicate Ambien is a prescription short-acting non-benzodiazepine hypnotic, which is approved for the short term treatment of insomnia. The Guidelines continue to state that Ambien should be used safely only for a short period of time. The clinical evaluation on 01/23/2014 does not indicate a diagnosis of insomnia. In addition, the injured worker had complaints of pain but did not indicate pain effected her sleep. It is indicated that her current medications include Ambien. The treatment plan is a 3 months' refill for Ambien. The request for Ambien does not include a frequency. The provider's rationale for Ambien is not provided within the documentation. The Guidelines only recommend a short term therapy of Ambien. Therefore, the request for Ambien 5 mg quantity 90 is not medically necessary.

Zanaflex 4 mg, QTY: 180: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for pain).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63-66.

Decision rationale: The request for Zanaflex 4 mg quantity 180 is not medically necessary. The Chronic Pain Medical Treatment Guidelines recommend non-sedating muscle relaxants with caution as a second line option for short term treatment of acute exacerbations in patients with chronic low back pain. The Guidelines also indicate that Zanaflex may provide benefit as an adjunct treatment for fibromyalgia. According to the clinical evaluation on 01/23/2014 the injured worker's complaints of pain were bilateral upper extremity regions. The documentation fails to indicate low back pain or fibromyalgia. The provider's rationale for the requested Zanaflex is not provided. The request fails to indicate a frequency. Therefore, the request for Zanaflex 4 mg quantity 180 is not medically necessary.

Phenergan 25 mg, QTY: 180: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Antiemetics (for opioid nausea).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Antiemetics.

Decision rationale: The request for Phenergan 25 mg quantity 180 is not medically necessary. The Official Disability Guidelines do not recommend antiemetics for nausea and vomiting secondary to chronic opioid use. The injured worker's current medications include opioids and it is indicated in the treatment plan that the injured worker is having 3 months' refills on her opioids. The documentation provided does not indicate any efficacy of the medication Phenergan. The provider's rationale for the requested Phenergan is not provided. In addition, a frequency for the request of Phenergan is not noted in the documentation. Therefore, the request for Phenergan 25 mg quantity 180 is not medically necessary.