

Case Number:	CM14-0035616		
Date Assigned:	06/23/2014	Date of Injury:	01/19/2013
Decision Date:	08/26/2014	UR Denial Date:	03/05/2014
Priority:	Standard	Application Received:	03/24/2014

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 and Rehabilitation, has a subspecialty in Neuromuscular Medicine and is licensed to practice in Maryland. 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 57 year old female with a work injury dated 1/19/13. The diagnoses include cervical sprain/strain, shoulder sprain/strain, carpal tunnel syndrome, and wrist pain. Under consideration is a request for Anaprox 550mg #60; Protonix 20mg #30; additional chiropractic bilateral wrist and forearms right shoulder two times a week for six weeks. There is a primary treating physician (PR-2) document dated 2/2/5/14 that states that the patient's condition is the same. She complains of bilateral shoulder, bilateral wrist, and bilateral forearm tenderness and pain. The objective findings are unchanged with limited range of motion in the shoulder, forearms, and wrist. The treatment plan states to continue chiropractic care, and medications. The patient is on temporary total disability.

IMR ISSUES, DECISIONS AND RATIONALES

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

Anaprox 550mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Non-Steroidal Anti-Inflammatory Drug (NSAIDs) Page(s): 67-68.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-inflammatory medications, Naproxen Page(s): 22, 73.

Decision rationale: Anaprox 550mg #60 is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The MTUS does state that anti-inflammatories are the traditional first line of treatment, to reduce pain so activity and functional restoration can resume, but long-term use may not be warranted. The documentation indicates that the patient has been on Anaprox since at least April of 2013 without evidence of significant functional improvement as defined by the MTUS or improvement in symptoms. The request for continued Anaprox 550mg #60 is not medically necessary.

Protonix 20mg #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI symptoms & cardiovascular risk Page(s): 69.

Decision rationale: Protonix 20mg #30 is not medically necessary per MTUS Guidelines. There is no history that patient meets MTUS criteria for a proton pump inhibitor including: (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAIDs (e.g., NSAIDs + low-dose ASA). California Medical Treatment Utilization Schedule Chronic Pain Guidelines do not support Proton Pump Inhibitor medication as treatment in the absence of symptoms or risk factors for gastrointestinal disorders.

Additional Chiropractic bilateral wrist and forearms right shoulder two times a week for six weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & Manipulation Page(s): 58-60.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & Manipulation Page(s): 58, 59. Decision based on Non-MTUS Citation Medical Treatment Utilization Schedule--Definitions p. 1 (definition of functional improvement).

Decision rationale: Additional chiropractic bilateral wrist and forearms right shoulder two times a week for six weeks is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The guidelines indicate that therapeutic care involves a trial of 6 visits over 2 weeks, with evidence of objective functional improvement with a total of up to 18 visits. The documentation indicates that the patient has had chiropractic care in the past. There is no evidence of acute flare up. Without documentation of functional improvement as defined by the MTUS, additional therapy is not medically necessary.