

Case Number:	CM14-0036264		
Date Assigned:	07/16/2014	Date of Injury:	09/30/2013
Decision Date:	08/14/2014	UR Denial Date:	03/19/2014
Priority:	Standard	Application Received:	03/25/2014

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 Emergency 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:

Patient with reported date of injury on 9/30/2013. Mechanism of injury was described as a fall from a ladder. Patient has a diagnosis of R wrist pain and strain, possible ulnar entrapment neuropathy, lumbar spine sprain/strain, multilevel disc protrusion of lumbar spine L4-5 and L5-S1 and lower extremity pain. Medical records reviewed. Last report available until 5/27/14. The original requests for services was not provided. The requests were extrapolated from the UR report. Patient complains of R wrist pain, numbness and tingling of R wrist to R elbow. Patient complains of low back pain radiating to both legs. R side worst than L side. Objective exam reveals tenderness to R wrist mostly to ulnar side. Radial deviation deformity. Limited range of motion. Decreased sensation to R ring and small finger. Strength in arm is normal. Lumbar exam reveals tenderness with spasticity of lumbosacral area. Decreased range of motion. Straight leg raise positive of R to 50degrees. Painful sciatic notch. No medication list was provided. It is no known what medications patient is on in any of the provided records. Urine drug screen on 2/23/14 was provided and appropriate. Independent Medical Review is for MRI of R wrist, Ultram, Prilosec and topical ointment. Prior UR on 3/19/14 recommended approval of referral to a spinal surgeon, ophthalmologist, naproxen and modified prescription of Ultram to 40tablets. It denied MRI of R wrist, Ultram, prilosec and topical ointment. There are 2 requests for services dated 2/6/14 and 3/19/14 with 2 Ultram requests.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI of the right wrist: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 271-273.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 269.

Decision rationale: As per ACOEM Guidelines, MRI of wrist is limited compared to other imaging and other studies. It is most useful at detecting infections. There is no documentation to support use of MRI of wrist. Pain and symptoms from wrist is chronic and has been ongoing for many months with no change in symptoms. There is no provided explanation as to what pathology or problem requires an MRI of the wrist. MRI of Right wrist is not medically necessary.

Ultram: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.24.2 Page(s): 93-94.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78.

Decision rationale: Tramadol/Ultram is a Mu-agonist, an opioid-like medication. As per MTUS Chronic pain guidelines, documentation requires appropriate documentation of analgesia, activity of daily living, adverse events and aberrant behavior. Documentation does not meet the appropriate documentation or analgesia criteria. The prescription is also incomplete with no total number of tablets requested. This request is also a duplicate. Another request dated 3/19/14 was partially approved for 40tablets. Due to incomplete prescription and not meeting criteria, this prescription for Ultram is not medically necessary.

Prilosec: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms and Cardiovascular Risks Page(s): 68-69.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines <NSAIDs, GI symptoms and cardiovascular risks>, page(s) <68-69> Page(s): 68-69.

Decision rationale: There is no documentation provided as to why prilosec was requested. Omeprazole/prilosec is a proton-pump inhibitor used for dyspepsia from NSAID use or gastritis/peptic ulcer disease. As per MTUS guidelines, PPIs may be used in patients with high risk for gastric bleeds or problems or signs of dyspepsia. Patient does not meet any high risk criteria to warrant PPIs and there is no documentation provided to support NSAID related dyspepsia. Therefore, the request is not medically necessary.

Topical ointment: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.24.2 Page(s): 111-113.

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

Decision rationale: As per UR report, the topical ointment is in fact 2 topical compounded products. Products requested is Flurbiprofen/capsaicin/menthol/camphor (10%/.25%/2%/1%) #120grams and Ketoprofen/Cyclobenzaprine/Lidocaine (10%/3%/5%) #120grams. As per MTUS guidelines Any compound product that contains a drug or drug class that is not recommended is not recommended. Flurbiprofen/capsaicin/menthol/camphor (10%/.25%/2%/1%) #120grams. 1)Flurbiprofen: Shown to be superior to placebo. It should not be used long term. There is no evidence of efficacy for spinal pain or osteoarthritis of spine. Pt has spinal neck and low back pain and therefore does not meet indication for use. There is no documentation to support where this topical compound is to be used therefore it is not recommended. 2)Capsaicin: Data shows efficacy in muscular skeletal pain and may be considered if conventional therapy is ineffective. Patient still has some pain at baseline but appears to respond and is well controlled with oral medications. There is no documentation of treatment failure or a successful trial of capsaicin. It is not recommended. 3)Menthol/Camphor: Are non active fillers that may have some topical soothing properties. B)Ketoprofen /Cyclobenzaprine/Lidocaine (10%/3%/5%) #120grams. 1)Ketoprofen: Not FDA approved for topical applications. Another topical NSAID ie. flurbiprofen was also requested. Duplicated double topical NSAID can lead to toxicity and use of a non-FDA approved application of a medication when there are multiple other topical NSAIDs is not medically necessary. 2)Cyclobenzaprine: Not recommended for topical application. 3)Lidocaine: Only recommended for neuropathic pain. No documentation on where this is to be used. Both requested topical compounds have multiple not-recommended components and are not medically necessary. The request for Topical ointment is not medically necessary.