

Case Number:	CM14-0046232		
Date Assigned:	07/02/2014	Date of Injury:	05/05/2009
Decision Date:	09/17/2014	UR Denial Date:	03/18/2014
Priority:	Standard	Application Received:	04/14/2014

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 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:

The injured worker is a 58-year-old female who reported an injury on 05/05/2009. The mechanism of injury was not specifically stated. The current diagnoses include left De Quervain's tenosynovitis, left MCP dislocation, and sleep disorder. The latest physician progress report submitted for this review is documented on 02/13/2014. The injured worker presented with complaints of severe pain in the left hand. Previous conservative treatment includes injection therapy and medication management. Physical examination revealed swelling, multiple insertion scars, decreased range of motion, and diminished grip strength with reduced sensation. Treatment recommendations at that time included a hand surgeon referral, a refill of the current medication regimen, and a followup visit in 4 weeks. A previous Request for Authorization form was submitted on 01/13/2014 for omeprazole DR 20 mg, Ambien 10 mg, Norco 10/325 mg, and Medrox pain relief ointment.

IMR ISSUES, DECISIONS AND RATIONALES

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

Omeprazole DR 20mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS and Gastrointestinal Symptoms Page(s): 68.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68-69.

Decision rationale: California MTUS Guidelines state proton pump inhibitors are recommended for patients at intermediate or high risk for gastrointestinal events. Patients with no risk factor and no cardiovascular disease do not require the use of a proton pump inhibitor, even in addition to a nonselective NSAID. There is no documentation of cardiovascular disease or increased risk factors for gastrointestinal events. There is also no frequency listed in the request. As such, the request is not medically necessary.

Medrox ointment: Upheld

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

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

Decision rationale: California MTUS Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is no documentation of a failure to respond to first line oral medication prior to the initiation of a topical analgesic. There is also no strength, frequency, or quantity listed in the request. As such, the request is not medically necessary.

Zolpidem Tartrate 10mg #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Integrated Treatment/Disability Duration Guidelines - Stress and Mental Illness Chapter.

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

Decision rationale: The Official Disability Guidelines state insomnia treatment is recommended based on etiology. Ambien is indicated for the short-term treatment of insomnia with difficulty of sleep onset for 7 to 10 days. The injured worker has continuously utilized this medication since 10/2013 without any evidence of functional improvement. There is also no frequency listed in the request. As such, the request is not medically necessary.

Hydrocodone APAP 10/325mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use Page(s): 76*80.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

Decision rationale: The Official Disability Guidelines state insomnia treatment is recommended based on etiology. Ambien is indicated for the short-term treatment of insomnia with difficulty of sleep onset for 7 to 10 days. The injured worker has continuously utilized this medication since 10/2013 without any evidence of functional improvement. There is also no frequency listed in the request. As such, the request is not medically necessary.