

Case Number:	CM14-0062338		
Date Assigned:	07/11/2014	Date of Injury:	03/05/2012
Decision Date:	08/11/2014	UR Denial Date:	04/14/2014
Priority:	Standard	Application Received:	05/05/2014

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 Pain Medicine and is licensed to practice in New York and Texas. 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 45 year old female injured on 03/05/12 due to an undisclosed mechanism of injury. Current diagnoses include chronic recurrent severe tenosynovitis of the bilateral wrists, DeQuervain's disease of the bilateral wrists, chronic carpal tunnel syndrome of the bilateral wrists, and chronic epicondylitis of the bilateral elbows. The clinical note dated 01/27/14 indicated the injured worker presented status post bilateral upper extremity surgery on 05/03/13 and 10/23/13. Physical examination revealed weakened grip to the right with no sensation deficits, right elbow pain with palpation, flexion tendon pain with palpation and grip. The injured worker was advised to use weights to increase strength. The clinical note dated 03/23/14 indicated the injured worker presented with pain to lateral elbow with passive range of motion and weakened grip. A request for a steroid injection to the right elbow and the right wrist due to flare up of pain was to be submitted. Prescriptions for Ibuprofen 800mg, Omeprazole 20mg, Hydrocodone/Acetaminophen 10/325mg, and a compounded cream submitted. The initial request for Hydrocodone/Acetaminophen #60, Omeprazole 20mg #60, Flurbiprofen 20%, Lido 5%, Menthol 5%, Camp 1%, Tramadol 15%/ Dextro 10%/Cap 0.025% was initially non-certified on 04/14/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hydrocodone/Acetaminophen #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for Use of Opioids Page(s): 77.

Decision rationale: As noted on page 77 of the Chronic Pain Medical Treatment Guidelines, patients must demonstrate functional improvement in addition to appropriate documentation of ongoing pain relief to warrant the continued use of narcotic medications. There is no clear documentation regarding the functional benefits or any substantial functional improvement obtained with the continued use of narcotic medications. As the clinical documentation provided for review does not support an appropriate evaluation for the continued use of narcotics as well as establish the efficacy of narcotics, the request for Hydrocodone/Acetaminophen #60 is not medically necessary.

Omeprazole 20 mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

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

Decision rationale: As noted in the Official Disability Guidelines - Online version, Pain Chapter, proton pump inhibitors (PPI) are indicated for patients at intermediate and high risk for gastrointestinal events with concurrent use of non-steroidal anti-inflammatory drug use. There is no indication that the patient is at risk for gastrointestinal events requiring the use of proton pump inhibitors. Furthermore, long-term PPI use (> 1 year) has been shown to increase the risk of hip fracture. As such, the request for Omeprazole 20mg #60 cannot be established as medically necessary.

Flurbiprofen 20%Lido 5% Menthol 5%/Camp 1%: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics.

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

Decision rationale: As noted on page 111 of the Chronic Pain Medical Treatment Guidelines, the safety and efficacy of compounded medications has not been established through rigorous clinical trials. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is no indication in the documentation that these types of medications have been trialed and/or failed. Further, California Medical Treatment Utilization Schedule, Food and Drug Administration, and Official Disability

Guidelines require that all components of a compounded topical medication be approved for transdermal use. This compound contains flurbiprofen which have not been approved for transdermal use. In addition, there is no evidence within the medical records submitted that substantiates the necessity of a transdermal versus oral route of administration. Therefore, Flurbiprofen 20%/Lido 5% Menthol 5%/Camp 1% is not medically necessary as it does not meet established and accepted medical guidelines.

Tramadol 15%/Dextro 10%/Cap 0.025%: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics.

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

Decision rationale: The safety and efficacy of compounded medications has not been established through rigorous clinical trials. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is no indication in the documentation that these types of medications have been trialed and/or failed. Further, California Medical Treatment Utilization Schedule, Food and Drug Administration and Official Disability Guidelines require that all components of a compounded topical medication be approved for transdermal use. This compound contains tramadol and dextro which have not been approved for transdermal use. In addition, there is no evidence within the medical records submitted that substantiates the necessity of a transdermal versus oral route of administration. Therefore, Tramadol 15%/Dextro 10%/Cap 0.025% is not medically necessary as it does not meet established and accepted medical guidelines.