

Case Number:	CM14-0084748		
Date Assigned:	07/21/2014	Date of Injury:	08/13/2010
Decision Date:	09/19/2014	UR Denial Date:	05/30/2014
Priority:	Standard	Application Received:	06/06/2014

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 Illinois. 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 29-year-old male who reported an injury on 08/13/2010 that reportedly occurred when the injured worker bent back his wrist and hit it against the metal edge of a trailer. The worker's treatment history included topical analgesics, medications, injections, surgery, and physical therapy. On 02/10/2014 he was treated with a cortisone injection to the left wrist. He felt the injection did not help at all. The injured worker was evaluated on 03/17/2014, and it was documented the injured worker complained of continued pain in the left arm with most severe pain on the left dorsal wrist. Within the documentation, the provider noted there was a bone scan done on 07/19/2013, and it was normal. Physical examination: the injured worker had full range of motion of his cervical spine without pain or tenderness. The Spurling's test was negative. Upper extremity physical examination of the shoulder right/left was normal. At the forearm, there was tenderness on the left volar and dorsal. There was slight atrophy in the left forearm when compared to the right. At the left wrist there was tenderness at TFCC, snuffbox/scaphoid, SL interval, and DRUJ. There was significant weakness of the wrist flexion/extension on the left when compared to the right. Grip strength of the left hand was 27/32/31. It was noted that the injured worker would require ongoing intermittent use of anti-inflammatory medication. He may require non-narcotic pain medication. Medications included Voltaren 100 mg, Prilosec 20 mg, Methoderm gel, and tramadol extended release 150 mg. Diagnosis included status post trauma to the left wrist 06/2010, severe disuse atrophy of the left arm due in part to prolonged chronic pain management. The Request for Authorization dated 07/10/2014 was for Methoderm gel 120 gm, Omeprazole 20 mg, and Tramadol 150 mg. The provider's rationale was not submitted for this review. The authorization dated 06/05/2014 was for Methoderm ointment, Omeprazole, Voltaren, and Tramadol. However, the rationale was not submitted for this review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retro Mentoderm Gel 120 gm (date of service 2/10/14): Upheld

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

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

Decision rationale: The requested is not medically necessary. The California Medical Treatment Utilization Schedule (MTUS) guidelines state that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. The guidelines also state that any compounded product contains at least one drug (or drug class) that is not recommended. Mentoderm ointment contains at least one or more drug class. The guidelines state that there are no other commercially approved topical formulation of lidocaine (whether creams, lotions, or gels) that are indicated for neuropathic pain other than Lidoderm. The proposed gel contains methyl salicylate and menthol. Furthermore, there was no documentation provided on conservative care measures such as physical therapy or pain management. In addition, there was no documentation provided on frequency or location where the Mentoderm ointment would be applied and unspecified quantity of the ointment was not provided. As such, the request for retrospective request for Retro Mentoderm Gel 120 gm (date of service 02/10/2014) is not medically necessary.

Voltaren 100 mg (date of service 2/10/2014): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (Non-steroidal anti-inflammatory drugs Page(s): 67.

Decision rationale: The requested not medically necessary. The Chronic Pain Medical Treatment Guidelines recommend that Motrin is used as a second line treatment after acetaminophen, there is conflicting evidence that NSAIDs are more effective than acetaminophen for acute LBP. For acute low back pain with sciatica a recent Cochrane review (included 3 heterogeneous randomized controlled trials) found no differences in treatment with NSAIDs versus. Placebo. In patients with axial low back pain this same review found that NSAIDs were not more effective than acetaminophen for acute low back pain and that acetaminophen have fewer side effects. There was lack of documentation of outcome measurements of conservative care measurements and home exercise regimen. In addition, the provider failed to indicate long-term functional goals for the injured worker. There was lack of documentation stating the efficiency of the Voltaren for the injured worker. There was a lack of documentation regarding average pain, intensity of the pain and longevity of the pain after the Voltaren taken by the injured worker. The request for Voltaren did not include the frequency or

duration. Given the above, the request for the Voltaren 100 mg (date of service 02/10/2014) is not medically necessary.

Prilosec 20 mg (date of service 2/10/2014): Upheld

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

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

Decision rationale: c) My rationale for why the requested treatment/service is or is not medically necessary: The requested is not medically necessary. Per California Medical Treatment Utilization Schedule (MTUS) Guidelines, Protonix is recommended for patients taking NSAIDs who are at risk of gastrointestinal events. The provider failed to submit medications for the injured worker. The documentation provided did not indicate that the injured worker was having gastrointestinal events. In addition, the request lacks the frequency or duration of the medication for the injured worker. Given the above, the request for Prilosec 20 mg (date of service 02/10/2014) is not medically necessary.

Retro Tramadol 150 mg (date of service 2/10/14): Upheld

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

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

Decision rationale: d) My rationale for why the requested treatment/service is or is not medically necessary: The request for retro Tramadol 150 mg (date of service 02/10/2014) is not medically necessary. The California Medical Treatment Utilization Schedule (MTUS) guidelines state that criteria for use for ongoing- management of opioids include ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. There was lack of evidence of opioid medication management and average pain, intensity of pain, or longevity, of pain relief. In addition, the request does not include the frequency. In addition, there lack of evidence of outcome measurements of conservative care such as, physical therapy or home exercise regimen outcome improvements noted for the injured worker. The documentation submitted for review the injured worker was negative for Opioid usage. The request submitted given the above, the request for is not supported by the California Medical Treatment Utilization Schedule (MTUS) Guidelines recommendations. As such, the request is not medically necessary.