

Case Number:	CM14-0085412		
Date Assigned:	07/23/2014	Date of Injury:	06/05/2012
Decision Date:	10/29/2014	UR Denial Date:	05/30/2014
Priority:	Standard	Application Received:	06/09/2014

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 Family 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:

The injured worker is a 62 year old female whose date of injury is 06/05/12. She is status post probable ganglion cyst excision in December 2012. Electrodiagnostic testing on 02/10/14 reported findings indicative of moderate left and mild right carpal tunnel syndrome; no evidence of ulnar neuropathy or cervical radiculopathy. Progress report dated 05/12/14 notes that the injured worker has not had any long lasting relief with acupuncture. A trial of 6 functional restoration visits for the right wrist/hand was recommended. Medications including Norco, Protonix, and Orudis were prescribed. A previous utilization review dated 05/30/14 denied functional restoration program and Protonix, but approved Norco and Orudis.

IMR ISSUES, DECISIONS AND RATIONALES

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

Functional Restoration Therapy 2 x 6 to Right Wrist/Hand: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Multidisciplinary pain management programs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic pain programs (functional restoration programs) Page(s): 30 of 127.

Decision rationale: CA MTUS provides that outpatient pain rehabilitation programs may be considered medically necessary when all of the following criteria are met: (1) An adequate and

thorough evaluation has been made, including baseline functional testing so follow-up with the same test can note functional improvement; (2) Previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement; (3) The patient has a significant loss of ability to function independently resulting from the chronic pain; (4) The patient is not a candidate where surgery or other treatments would clearly be warranted (if a goal of treatment is to prevent or avoid controversial or optional surgery, a trial of 10 visits may be implemented to assess whether surgery may be avoided); (5) The patient exhibits motivation to change, and is willing to forgo secondary gains, including disability payments to effect this change; & (6) Negative predictors of success above have been addressed. The records indicate that the injured worker has continuing complaints of right wrist pain with numbness and tingling status post ganglion cyst excision. She has had recent acupuncture without significant improvement; however, there is no indication that the injured worker has had any recent physical therapy for the right wrist. She has objective findings of carpal tunnel syndrome on EMG/NCV. It does not appear that the injured worker has exhausted lower levels of care prior to consideration of a multidisciplinary functional restoration program. There is no documentation that the injured worker has undergone a psychological evaluation addressing negative predictors of success. Based on the clinical information provided, the request for Functional Restoration Therapy 2 x 6 to Right Wrist/Hand is not recommended as medically necessary.

Protonix 20mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS (non-steroidal anti-inflammatory drugs) GI symptoms & car.

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: The submitted clinical records indicate the injured worker has chronic pain associated with a workplace injury. She has been maintained on oral medications which include Norco, Orudis, and Protonix. The record does not indicate that the injured worker suffers from medication induced gastritis or is at an increased risk for the development of this condition. As such, the medical necessity for the continued use of this medication is not medically necessary.