

Case Number:	CM13-0006876		
Date Assigned:	03/07/2014	Date of Injury:	01/11/2002
Decision Date:	01/22/2015	UR Denial Date:	07/22/2013
Priority:	Standard	Application Received:	08/05/2013

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 Rehab, 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:

This is a 60 year old female who sustained a work related injury on January 11, 2002. The mechanism of injury is not provided. The most current documentation submitted for review notes that the injured worker continued to have bilateral shoulder pain, worse on the left. The pain radiated into the bilateral forearms, worse on the left arm. She also reported pain in the bilateral palms of the hands. The pain occurred on the ulnar and radial surface. Daily function was noted to be limited, but no objective limitations were noted. Physical examination revealed limited range of motion of the upper extremities. The abduction and flexion of the shoulders was limited at end ranges. There was slight limited range of motion on the left greater than the right wrist and fair upper extremity strength. Tenderness was noted over the left anterior and superior shoulder. Sensation was equal bilaterally. The documentation notes that the injured worker used an H-Wave Unit two to three times a week with very good pain relief. She also used wrist splints at night. Diagnoses include Carpel Tunnel Syndrome, pain in the joint shoulder region, pain in the forearm, unspecified disorders joint and unspecified myalgia and myositis. Work status is not noted. The treating physician requested Valium 10 mg # 60 as needed for spasms, Prevacid 30 mg # 60 for gastroesophageal reflux disease, over the counter products for pain control and a return visit in three months for evaluation and treatment. Utilization Review evaluated and denied the requests on July 22, 2013. Utilization Review makes reference to a progress note dated July 15, 2013 which was not submitted for review. The request for Valium was denied due to no documentation of the injured worker having had muscle spasms. Per Utilization Review documentation the injured worker was unable to tolerate non-steroidal anti-inflammatory medications. Prevacid is a proton pump inhibitor useful in the treatment of gastroesophageal reflux disease and as a gastric protectant for individuals utilizing non-steroidal anti-inflammatory drugs. There was no documentation of which over the counter medications

were requested for pain control. Therefore, the Valium, Prevacid and over the counter medications are not medically necessary. The documentation does not indicate any reason why a follow-up visit in three months is needed and therefore is not medically necessary. MTUS Chronic Pain Medical Treatment Guidelines and Official Disability Guidelines, Pain Chapter were referenced.

IMR ISSUES, DECISIONS AND RATIONALES

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

VALIUM 10MG, #60: 1PO Q 12 HOURS PRN SPASMS: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Work Loss Data Institute, LLC. www.odg-twc.com; Section: Pain, Official Disability Guidelines, Pain Chapter, updated June 2013

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

Decision rationale: CA MTUS Chronic Pain Medical Treatment Guidelines state that benzodiazepines range of action includes sedative/hypnotic, anxiolytic, anticonvulsant, and muscle relaxant. They are not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. However, with a 2002 original date of injury, it is unclear how long the patient has been taking Valium. Guidelines do not recommend chronic use, especially in the absence of clear documentation of objective functional benefit derived from its use. Additionally, there is no documentation of muscle spasm or acute interval muscular exacerbation. Therefore, the request for Valium 10 mg #60: 1 PO Q12 hours prn spasms was not medically necessary.

PREVACID 30MG, #60: 1 PO Q 12 HOURS OR GERD: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI symptoms & cardiovascular risk Page(s): 68. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: FDA (Lansoprazole)

Decision rationale: CA MTUS and the FDA support proton pump inhibitors in the treatment of patients with GI disorders such as; gastric/duodenal ulcers, GERD, erosive esophagitis, or patients utilizing chronic NSAID therapy. Lansoprazole is a proton pump inhibitor, PPI, used in treating reflux esophagitis and peptic ulcer disease. There is no comment that relates the need for the proton pump inhibitor for treating gastric symptoms associated with the medications used in treating this industrial injury. In general, the use of a PPI should be limited to the recognized indications and used at the lowest dose for the shortest possible amount of time. There remains

no diagnosis of GERD or other GI condition or chronic NSAID use. Therefore, the request for Prevacid 30 mg #60: 1 PO Q 12 hours for GERD was not medically necessary.

OTC PRODUCTS FOR PAIN CONTROL: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: CA MTUS does not address this issue. ODG states that Relief of pain with the use of medications is generally temporary, and measures of the lasting benefit from this modality should include evaluating the effect of pain relief in relationship to improvements in function and increased activity. Before prescribing any medication for pain the following should occur: determine the aim of use of the medication; determine the potential benefits and adverse effects; determine the patient's preference. However, regarding the request for OTC products for pain control, there is no specification of the requested medication, frequency, or duration. Without this information, the request is not certifiable. Therefore, the request for OTC products for pain control was not medically necessary.

RETURN IN 3 MONTHS FOR EVALUATION AND TREATMENT: Overturned

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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 Office Visits

Decision rationale: CA MTUS does not specifically address the issue. ODG states that evaluation and management (E&M) outpatient visits to the offices of medical doctor(s) play a critical role in the proper diagnosis and return to function of an injured worker, to monitor the patient's progress, and make any necessary modifications to the treatment plan. The determination of necessity for an office visit requires individualized case review and assessment, being ever mindful that the best patient outcomes are achieved with eventual patient independence from the health care system through self care as soon as clinically feasible. The patient continues to have active issues with clinically significant objective findings on physical examination. Periodic office visit follow for re-evaluation and management is recommended. Therefore, the request for Return in 3 months for evaluation and treatment was medically necessary.