

Case Number:	CM15-0104905		
Date Assigned:	06/09/2015	Date of Injury:	10/01/2013
Decision Date:	07/13/2015	UR Denial Date:	04/29/2015
Priority:	Standard	Application Received:	06/01/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: New York

Certification(s)/Specialty: Anesthesiology

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 44 year old female, who sustained an industrial injury on 10/1/2013. She reported pain in her neck, head, right shoulder and right hand. Diagnoses have included cervical spine sprain/strain with right upper extremity radiculopathy, right rotator cuff tear, right wrist DeQuervain's tenosynovitis with subchondral cyst, gastritis and H. Pylori. Treatment to date has included physical therapy, acupuncture and medication. Per the progress report dated 1/29/2015, the injured worker complained of cervical spine pain rated 3/10 along with right sided pain. She complained of constant right shoulder pain rated 5/10. She complained of right wrist pain rated 4/10 along with swelling. Work status was modified duty with restrictions. According to the progress report dated 4/1/2015, the injured worker was seen for a gastrointestinal check. Gastrointestinal symptoms were improved. Per the progress report dated 4/9/2015, the physical exam revealed muscle guarding, spasm and tenderness in the cervical spine. There were trigger points in the upper trapezius. Impingement test was positive in the right shoulder. There was tenderness of the bilateral wrists. Finkelstein's was positive on the right wrist. Authorization was requested for Flurbiprofen cream, Ultram, Prilosec, Naproxen, Solar Care FIR Heating system and a physical performance test (Functional Capacity Evaluation).

IMR ISSUES, DECISIONS AND RATIONALES

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

Flurbiprofen Cream with 1 Refill: 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: According to the California MTUS Guidelines (2009), topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied topically to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control including, for example, NSAIDs, opioids, capsaicin, muscle relaxants, local anesthetics or antidepressants. In this case, there is no documentation provided necessitating Flurbiprofen cream. There is no documentation of intolerance to other previous medications. Flurbiprofen, used as a topical NSAID, has been shown in a meta-analysis to be superior to placebo during the first two weeks of treatment for osteoarthritis but either, not afterward, or with diminishing effect over another two-week period. There are no clinical studies to support the safety or effectiveness of Flurbiprofen in a topical delivery system (excluding ophthalmic). Medical necessity for the requested Fluriprofen cream has not been established. The requested treatment is not medically necessary.

Ultram 50 MG #60 with 1 Refill: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for the treatment of chronic pain Page(s): 93-96.

Decision rationale: According to the California MTUS, Tramadol (Ultram) is a synthetic opioid, which affects the central nervous system and is indicated for the treatment of moderate to severe pain. Per CA MTUS Guidelines, certain criteria need to be followed, including an ongoing review and documentation of pain relief and functional status, appropriate medication use, and side effects. Pain assessment should include current pain: last reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid, and the duration of pain relief. According to the medical records, there has been no documentation of the medication's analgesic effectiveness or functional improvement, and no clear documentation that the patient has responded to ongoing opioid therapy. Medical necessity of the requested medication has not been established. Of note, discontinuation of an opioid analgesic requires a taper to avoid withdrawal symptoms. The requested medication is not medically necessary.

Prilosec 20 MG #30 with 1 Refill: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines PPIs Page(s): 68. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) PPIs.

Decision rationale: According to CA MTUS (2009), proton pump inhibitors, such as Omeprazole (Prilosec), are recommended for patients taking NSAIDs with documented GI distress symptoms or specific GI risk factors. There is no documentation indicating the patient has any GI symptoms or GI risk factors. Risk factors include, age >65, history of peptic ulcer disease, GI bleeding, concurrent use of aspirin, corticosteroids, and/or anticoagulants or high-dose/multiple NSAIDs. There is no documentation of any reported GI complaints. Based on the available information provided for review, the medical necessity for Prilosec has not been established. The requested medication is not medically necessary.

Naproxen 550 MG #60 with 1 Refill: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-71.

Decision rationale: Naproxen is a non-steroidal anti-inflammatory drug (NSAID). Oral NSAIDs are recommended for the treatment of chronic pain and control of inflammation as a second-line therapy after acetaminophen. ODG states that NSAIDs are recommended for acute pain, osteoarthritis, acute low back pain (LBP) and acute exacerbations of chronic pain, and short-term pain relief in chronic LBP. There is no evidence of long-term effectiveness for pain or function. There is inconsistent evidence for the use of NSAIDs to treat long-term neuropathic pain. Guidelines recommended that the lowest effective dose be used for the shortest duration of time consistent with treatment goals. In this case, the patient had prior use of NSAIDs without any documentation of significant improvement. There was no documentation of subjective or objective benefit from use of this medication. Medical necessity of the requested medication has not been established. The request for Naproxen is not medically necessary.

Solar Care FIR Heating System Purchase: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Cold/Heat Packs.

Decision rationale: Far Infrared Ray (FIR) are electromagnetic waves in the portion of the spectrum just beyond visible light. FIR provides a specific target with deep, penetrating heat via direct energy conversion. According to the ODG, heat therapy is under study for shoulder

conditions. There is no specific indication for the use of the requested portable FIR heating system. There is no documentation indicating that other guideline accepted therapies for the treatment of chronic shoulder pain have been implemented. Medical necessity for the requested item has not been established. The requested item is not medically necessary.

Physical Performance Test: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Functional Capacity Evaluation Page(s): 48.

Decision rationale: The CA MTUS states that a functional capacity evaluation (FCE) is recommended under certain specific circumstances. The importance of an assessment is to have a measure that can be used repeatedly over the course of treatment to demonstrate improvement of function, or maintenance of function that would otherwise deteriorate. It should include work functions and or activities of daily living, self-report of disability, objective measures of the patient's functional performance and physical impairments. The guidelines necessitate documentation indicating case management is hampered by complex issues (prior unsuccessful return to work attempts, conflicting medical reports on precautions and/or fitness for modified job), injuries that require detailed exploration of a worker's abilities and clarification of all additional/secondary conditions in order to recommend an FCE. In this case, there is no documentation that any of the above conditions are present, which would require the completion of an FCE. There are no specific indications for an FCE. Medical necessity for the requested service has not been established. The requested service is not medically necessary.