Case Number:	CM15-0109999		
Date Assigned:	06/16/2015	Date of Injury:	07/05/2011
Decision Date:	09/29/2015	UR Denial Date:	05/26/2015
Priority:	Standard	Application Received:	06/08/2015

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: California
Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

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 49-year-old female, who sustained an industrial injury on 7/5/2011. She reported right thumb pain. Diagnoses have included right thumb IP-1 joint extension contracture, right thumb MCP-1 joint extension contracture, right thumb hypoesthesia and right thenar eminence chronic pain. Treatment to date has included occupational therapy, surgery, cortisone injections and medication. According to the progress report dated 5/21/2015, the injured worker complained of pain in right thumb region. She complained of being unable to reach her back due to pain. She stated she was getting more depressed. Objective findings revealed chronic pain in the A1 pulley region of the right thumb and poor movement of the thumb. The injured worker was temporarily totally disabled. Authorization was requested for additional occupational therapy to the right thumb, Functional Capacity Evaluation, Mirtazapine, Tramadol ER, Cyclobenzaprine, Omeprazole DR, Flurbiprofen transdermal cream, Cyclobenzaprine 10%/Gabapentin 10% transdermal cream and a DNA pharmacogenomics diagnostic test panel.

IMR ISSUES, DECISIONS AND RATIONALES

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

Additional Occupational Therapy 2 x 4: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine, Physical Therapy.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58-60.

Decision rationale: The MTUS Chronic Pain Medical Treatment Guidelines state that active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Continued physical therapy is predicated upon demonstration of a functional improvement. There is no documentation of objective functional improvement. Additional Occupational Therapy 2 x 4 is not medically necessary.

Functional Capacity Evaluation: 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) Fitness For Duty, Functional capacity evaluation (FCE).

Decision rationale: The Official Disability Guidelines state that a functional capacity evaluation is appropriate if, complex issues and the timing hamper case management is appropriate; such as if the patient is close to being at maximum medical improvement or additional clarification concerning the patient's functional capacity is needed. Functional capacity evaluations are not needed if the sole purpose is to determine a worker's effort or compliance, or the worker has returned to work. There is no documentation in the medical record to support a functional capacity evaluation based on the above criteria. Functional Capacity Evaluation is not medically necessary.

Mirtazapine 15mg #60 with 1 refill: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), Antidepressants for chronic pain.

Decision rationale: Mirtazapine (Remeron) is a noradrenergic and specific serotonergic antidepressant (NaSSA) used to treat major depressive disorder. According to the Official Disability Guidelines, antidepressants are not routinely recommended for non-neuropathic pain. Recommended as an option in depressed patients, but effectiveness is limited. Non-neuropathic

pain is generally treated with analgesics and anti-inflammatory. In guidelines for painful rheumatic conditions recommended by Perrot, it was suggested that antidepressants might be prescribed as analgesics in non-depressed patients, with the first-line choice being tricyclics initiated at a low dose, increasing to a maximally tolerated dose. Mirtazapine 15mg #60 with 1 refill is not medically necessary.

Tramadol ER #30 with 1 refill (dosage unspecified): Upheld

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

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

Decision rationale: The Chronic Pain Medical Treatment Guidelines state that continued or long-term use of opioids should be based on documented pain relief and functional improvement or improved quality of life. Tramadol is a centrally acting synthetic opioid analgesic and it is not recommended as a first-line oral analgesic. Despite the long-term use of Tramadol, the patient has reported very little, if any, functional improvement or pain relief over the course of the last 6 months. A previous utilization review decision provided the patient with sufficient quantity of medication to be weaned slowly off narcotic. Tramadol ER #30 with 1 refill is not medically necessary.

Cyclobenzaprine 7.5mg #90 with 1 refill: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 64.

Decision rationale: The MTUS Chronic Pain Treatment Guidelines do not recommend long-term use of muscle relaxants such as Cyclobenzaprine. The patient has been taking Cyclobenzaprine for an extended period, long past the 2-3 weeks recommended by the MTUS. The clinical information submitted for review fails to meet the evidence-based guidelines for the requested service. Cyclobenzaprine 7.5mg #90 with 1 refill is not medically necessary.

Omperazole DR 20mg #30 with 1 refill: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20-9792.26 Page(s): 68.

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines, prior to starting the patient on a proton pump inhibitor, physicians are asked to evaluate the patient and to determine if the patient is at risk for gastrointestinal events. Criteria used are: (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID. There is no documentation that the patient has any of the risk factors needed to recommend the proton pump inhibitor Omeprazole. Omeprazole DR 20mg #30 with 1 refill is not medically necessary.

Cyclobenzaprine 10%, Gabapentin 10%, Transdermal Cream: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20-9792.26 Page(s): 111-113.

Decision rationale: According to the MTUS, there is little to no research to support the use of many of these compounded topical analgesics. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. There is no evidence for use of any muscle relaxant as a topical product. Additionally, Gabapentin is not recommended. There is no peer-reviewed literature to support use. Cyclobenzaprine 10%, Gabapentin 10%, Transdermal Cream is not medically necessary.

Flurbiprofen 20% Transdermal Cream: Upheld

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

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

Decision rationale: According to the MTUS, there is little to no research to support the use of many of these Compounded Topical Analgesics. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Flurbiprofen topical is not supported by the MTUS. Flurbiprofen 20% Transdermal Cream is not medically necessary.

DNA Pharmacogenomic Diagnostic Test Panel: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 44.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20-9792.26 Page(s): 42.

Decision rationale: There is currently no evidence-based, peer-reviewed guidelines recommending genetic testing to determine hereditary predisposition to the addiction of

narcotics. There is currently no evidence-based guideline supporting that the knowledge of a patient's genetic propensity to addiction would change or guide the treatment in any way. A similar situation using cytokine DNA testing for pain is referenced in the MTUS Chronic Pain guidelines and is not recommended. DNA Pharmacogenomic Diagnostic Test Panel is not medically necessary.