Case Number:	CM15-0198121		
Date Assigned:	10/13/2015	Date of Injury:	04/30/2013
Decision Date:	12/01/2015	UR Denial Date:	09/10/2015
Priority:	Standard	Application Received:	10/08/2015

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, North Carolina
Certification(s)/Specialty: Family Practice

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 64 year old male, who sustained an industrial injury on 4-30-13. The injured worker was diagnosed as having carpal tunnel syndrome-bilateral; bilateral shoulder strain-sprain; bilateral medial epicondylitis. Treatment to date has included physical therapy; urine drug screening; medications. Diagnostics studies included EMG-NCV study bilateral upper extremities (3-24-15). Currently, the PR-2 notes dated 8-4-15 indicated the injured worker has had a right carpal tunnel release on 5-6-14. She continued complaints and an EMG-NCV study was completed on 3-24-15 showing bilateral carpal tunnel syndrome persistent. The EMG-NCV study of the upper extremities dated 3-24-15 impression reveals "Abnormal study. There is electrophysiologic evidence for bilateral median neuropathy at wrists consistent with bilateral carpal tunnel syndrome. No evidence for myopathy, cervical radiculopathy and plexopathy. Bilateral median nerve conduction delay was noted at wrists consistent with distal median neuropathy. Both motor and sensory component of median nerves were involved. This finding suggests bilateral carpal tunnel syndrome of moderate intensity. Needle examination showed no denervation potentials. No axonal neuropathy was noted." She was also diagnosed with bilateral shoulder and bilateral median nerve median epicondylitis pain of her elbows. His recommendations were possible injection into the carpal tunnel space, but also possible orthopedic hand surgical intervention for surgical release of the carpal tunnels. He recommended possible TENS unit for the bilateral hands pain. The consultation was done March 2015 and since then the injured worker has been looking for a primary care treating physician and has come to this office for this provider to take over her care. This provider documents "Current pain level on her right hand is a 6 out of 10 and left hand is 4 out of 10."

On physical examination, the provider documents "She does have severe pain in her both wrists, where she feels numbness in her fingertips. She has pain going up into her elbow on the medial epicondyle both elbows. Shoulders; however, has little complaints today. She has numbness and tingling in both fingers in all of the fingers except for her thumb. She states that she has a very difficult time discriminating with her hand and difficult time sewing and fine maneuvering. She has lost a log of strength in her hands. She has positive bilateral Tinel's sign. She has numbness and tingling in the median nerve distribution of both right and left hands. She also had numbness, tingling, and loss of sensation in both ulnar nerve distributions of the right and left hands. She has no evidence of neurological loss of her epicondyles of her bilateral elbows but she has pain over the medial epicondyle of both nerves possibly related to entrain pain from carpal tunnel." The treatment plan includes physical therapy-paraffin bath of hands and carpal tunnel complaints. He is also requesting medications. The medical documentation submitted for review does not define the initial date of when these medications were prescribed. A Request for Authorization is dated 10-7-15. A Utilization Review letter is dated 9-10-15 and non-certification for Omeprazole 20mg, 1 tablet twice per day, #60. A request for authorization has been received for Tizanidine 4mg, 1 tablet twice per day, #60.

IMR ISSUES, DECISIONS AND RATIONALES

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

Omeprazole 20mg, 1 tablet twice per day, #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk.

Decision rationale: CA MTUS Guidelines support the use of proton pump inhibitors (PPI) in cases where patients taking NSAIDs are at risk for GI events. Those at risk include patients with a history of PUD, GI hemorrhage, or perforation; those with concomitant use of ASA, corticosteroids or anticoagulants, and those of high dose/multiple NSAIDs and age greater than 65 years. In this case, the patient does not have any risk factors to justify the prophylactic use of Omeprazole. There is also no documentation of dyspepsia or other GI complaints and no documentation of the efficacy of Omeprazole. Therefore, the request is not medically necessary.

Tizanidine 4mg, 1 tablet twice per day, #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Muscle relaxants (for pain).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Muscle relaxants (for pain).

Decision rationale: Tizanidine is a muscle relaxant indicated for acute muscle spasms. Muscle relaxants have their greatest effects in the first 3-4 days of use and should be used no longer than 2-3 weeks. They are not indicated for long-term use. In this case, there is no documentation of acute muscle spasm requiring the use of a muscle relaxant. There is also no documentation of efficacy of this medication for the patient's complaints. Therefore, the request is not medically necessary or appropriate.