

Case Number:	CM15-0030792		
Date Assigned:	02/24/2015	Date of Injury:	03/21/2012
Decision Date:	05/08/2015	UR Denial Date:	01/23/2015
Priority:	Standard	Application Received:	02/19/2015

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, Public Health & General Preventive 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 61-year-old male who reported an injury on 03/31/2012. The mechanism of injury was not specifically stated. The current diagnoses include left middle finger distal phalanx fracture, left shoulder pain, cervical strain with radicular symptoms, bilateral carpal tunnel syndrome, left cubital tunnel syndrome, and secondary depression and anxiety. The injured worker presented on 12/12/2014 for a follow up evaluation with complaints of 4/10 upper extremity and 6/10 neck pain. The injured worker was utilizing a home TENS unit. Upon examination of the cervical spine, there was mild tenderness to palpation with muscle spasm on the left, 90% of normal flexion, 70% of normal extension, and 90% of normal left lateral flexion. Examination of the left shoulder and hand revealed tenderness at the acromioclavicular region, positive impingement sign, 110 degrees abduction 140 degrees flexion, mild swelling of the left hand with atrophy, and paresthesia in the 3rd, 4th, and 5th fingers. Treatment recommendations included a repeat MRI of the left shoulder, and neurosurgery consultation, continuation of Neurontin 300 mg, Norco 10/325 mg, Pennsaid 1.3%, Prozac 20 mg, Ambien 10 mg, Prilosec 20 mg, Promolaxin, and Zofran 4 mg. There was no Request for Authorization form submitted for this review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Pennsaid 1.3%: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Pain Chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter, Pennsaid (diclofenac sodium topical solution).

Decision rationale: The Official Disability Guidelines do not recommend Pennsaid as a first line treatment. The FDA approved Pennsaid topical solution in 2009 for the treatment of the signs and symptoms of osteoarthritis of the knee. In this case, there is no documentation of a failure of first line treatment prior to the initiation of Pennsaid topical solution. The injured worker does not maintain a diagnosis of osteoarthritis. Additionally, there is no evidence of objective functional improvement despite the ongoing use of this medication. The request as submitted also failed to indicate a frequency and quantity. Given the above, the request is not medically appropriate.

Prozac 20mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 13-16.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 107.

Decision rationale: California MTUS Guidelines state SSRIs are not recommended as treatment for chronic pain, but may have a role in treating secondary depression. In this case, the provider indicated that the injured worker was to continue the use of Prozac for relief of depression. However, there was no psychological examination provided. There is no mention of functional improvement despite the ongoing use of this medication. There is also no frequency listed in the request. As such, the request is not medically appropriate.

Ambien 10mg #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG (Pain Chapter) FDA (Ambien).

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

Decision rationale: The Official Disability Guidelines recommend insomnia treatment based on etiology. Ambien is indicated for the short term treatment of insomnia with difficulty of sleep onset for 7 to 10 days. The injured worker does not maintain a diagnosis of insomnia disorder.

The injured worker has also utilized the above medication since 04/2014. Guidelines do not recommend long term use of hypnotic medication. There is no evidence of a failure of nonpharmacologic treatment. There is also no frequency listed in the request. Given the above, the request is not medically appropriate.

Zofran ODT 4mg: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Pain Chapter.

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

Decision rationale: The Official Disability Guidelines do not recommend ondansetron for nausea and vomiting secondary to chronic opioid use. Zofran has been FDA approved for treatment of nausea and vomiting secondary to chemotherapy and radiation treatment. The injured worker does not meet the above mentioned criteria. There was also no frequency or quantity listed in the request. Given the above, the request is not medically appropriate.