

Case Number:	CM15-0033231		
Date Assigned:	02/26/2015	Date of Injury:	04/27/2012
Decision Date:	04/07/2015	UR Denial Date:	01/22/2015
Priority:	Standard	Application Received:	02/23/2015

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: Maryland

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Neuromuscular 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:

This 35-year-old female reported a work-related injury on 04/27/2012. According to the progress notes from the primary treating provider dated 2/6/15, the injured worker (IW) reports persistent right shoulder, wrist and hand pain rated 7/10, with some swelling of the right wrist, forearm and hand. The IW was diagnosed with chronic neck pain; right de Quervain's tenosynovitis; right shoulder adhesive capsulitis; right rotator cuff tendinitis with impingement and left shoulder pain. Previous treatments include medications, physical and occupational therapy, tendon sheath injection and bracing. The treating provider requests Promethazine 12.5mg, #60 (30-day supply); right wrist immobilizer/splint, custom fit; six to eight sessions of occupational therapy and six to eight sessions of psychotherapy treatment. The Utilization Review on 01/22/2015 non-certified the request for Promethazine 12.5mg, #60; right wrist immobilizer/splint, custom fit; six to eight sessions of occupational therapy and six to eight sessions of psychotherapy treatment. References cited were CA MTUS Chronic Pain Medical Treatment Guidelines and Official Disability Guidelines-Treatment for Worker's Compensation (ODG-TWC).

IMR ISSUES, DECISIONS AND RATIONALES

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

Promethazine 12.5 mg, sixty count: 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), Pain Management.

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)-Antiemetics (for opioid nausea).

Decision rationale: Promethazine 12.5mg, sixty count is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The MTUS states that antiemetics are not recommended for nausea and vomiting secondary to chronic opioid use. There is no high-quality literature to support any one treatment for opioid-induced nausea in chronic non-malignant pain patients. Promethazine is a phenothiazine. It is recommended as a sedative and antiemetic in pre-operative and post-operative situations. Multiple central nervous system effects are noted with use including somnolence, confusion and sedation. Tardive dyskinesia is also associated with use. This is characterized by involuntary movements of the tongue, mouth, jaw, and/or face. Choreoathetoid movements of the extremities can also occur. Development appears to be associated with prolonged treatment and in some cases can be irreversible. Anticholinergic effects can occur (dry mouth, dry eyes, urinary retention and ileus. The documentation does not indicate that the patient is using Promethazine for a sedative and antiemetic in pre and post op situations. The request for Promethazine is not medically necessary.

Right wrist immobilizer/splint custom fit: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 265. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Forearm, Wrist & Hand Procedure.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 264.

Decision rationale: Right wrist immobilizer/splint custom fit is medically necessary per the ACOEM guidelines. The ACOEM states that DeQuervain's tendinitis, if not severe, may be treated with a wrist-and-thumb splints and acetaminophen, then NSAIDs, if tolerated, for four weeks before corticosteroid injection is considered. The guidelines recommend limit motion of inflamed structures with wrist and thumb splint. The request for a custom fit brace for the right wrist for this patient is medically necessary.

Six to eight sessions of occupational therapy: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98 - 99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Procedure and Pain Procedure Summaries.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine Page(s): 98-99.

Decision rationale: Six to eight sessions of occupational therapy is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The MTUS recommends transition to an independent home exercise program. The request as written does not specify a body part for this therapy. Furthermore the amount of prior therapy is not clear as well as documented objective functional improvement from this therapy. Without clarification of this information additional occupational therapy cannot be certified and is not medically necessary.

Psychotherapy treatment, six to eight sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 101 - 102.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Psychological treatment Page(s): 101-102. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental illness and stress- Cognitive therapy for depression.

Decision rationale: Psychotherapy treatment, six to eight sessions is not medically necessary. Psychotherapy is recommended for appropriately identified patients during treatment for chronic pain. The ODG recommends up to 13-20 visits over 7-20 weeks (individual sessions), if progress is being made. The documentation indicates that the patient has had prior psychotherapy. The outcome and number of these visits are not clear. Without this information additional psychotherapy cannot be certified and therefore the request is not medically necessary.