

Case Number:	CM14-0163944		
Date Assigned:	10/08/2014	Date of Injury:	05/16/2012
Decision Date:	11/04/2014	UR Denial Date:	09/17/2014
Priority:	Standard	Application Received:	10/06/2014

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation, and is licensed to practice in Texas. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

Medical records reflect the claimant is a 38 year old female who sustained a work injury on 5-16-12. Initial pain management evaluation on 8-15-14 notes the claimant reports left wrist/hand pain as her chief complaints. She also reports upper back, left shoulder/arm pain, and left elbow pain. On exam, the claimant has trigger points at the cervical spine as well as tenderness. She had decrease sensation at left forearm and middle three digits. There was grip weakness. MRI of the cervical spine dated 3-3-14 showed HNP at C6-C7. Diagnosis includes cervical radiculopathy, medial epicondylitis, and myofascial pain syndrome. Recommendations includes neuromuscular treatment, Naproxen, topical neuropathic anti-inflammatory creams, Protonix for gastric prophylaxis, home exercise program. Orthopedic QME supplemental report dated 8-18-14 notes the claimant has a diagnosis of crush injury to the right upper extremity, strain of the right shoulder and musculoligamentous strain of the cervical spine and thoracic spine. There was a recommendation or EMG/NCS of the upper extremities, x-rays of the cervical spine, right shoulder, right hand as well as MRI of the right shoulder.

IMR ISSUES, DECISIONS AND RATIONALES

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

Neurostimulator treatment over 60 days, QTY: 4: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines transcutaneous electrotherapy Page(s): 114-117. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), pain chapter - percutaneous electrical nerve stimulation

Decision rationale: Chronic Pain Medical Treatment Guidelines as well as ODG notes that not recommended as a primary treatment modality, but a trial may be considered, if used as an adjunct to a program of evidence-based functional restoration. There is an absence in documentation noting that this claimant has had a trial with daily pain diaries noting functional and documented improvement. Therefore, the medical necessity of this request is not established.

Urine drug screen: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, steps to avoid misuse/addiction Page(s): 94-95.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ongoing opioids Page(s): 78.

Decision rationale: Chronic Pain Medical Treatment Guidelines notes that the use of drug screening or inpatient treatment is indicated in patients with issues of abuse, addiction, or poor pain control. There is an absence in documentation noting that this claimant has abuse or misuse issues or that she is provided with opioids. Therefore, the medical necessity of this request is not established.

Naproxen 550mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAID's Page(s): 67-73.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 67-73. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), pain chapter - NSAIDs

Decision rationale: Chronic Pain Medical Treatment Guidelines as well as ODG reflect that NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain. There is an absence in documentation documenting medical necessity for the long term use of an NSAID. There is no documentation of functional improvement with this medication. Therefore, the medical necessity of this request is not established.

Topical Neuropathic and anti-inflammatory creams (no specific meds, dosage, frequency or duration): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

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

Decision rationale: Chronic Pain Medical Treatment Guidelines notes that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is an absence in documentation noting that this claimant failed first line of treatment or that he cannot tolerate the oral medications that are being prescribed. Additionally, this request is nonspecific. No description of the medication or quantity provided. Therefore, the medical necessity of this request was not established.

Protonix 10mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms.

Decision rationale: Chronic Pain Medical Treatment Guidelines notes that PPI are indicated for patients with intermediate or high risk for GI events. There is an absence in documentation noting that this claimant has secondary GI effects due to the use of medications or that she is at an intermediate or high risk for GI events. Therefore, the medical necessity of this request is not established