

Case Number:	CM14-0180526		
Date Assigned:	11/05/2014	Date of Injury:	03/30/2012
Decision Date:	12/09/2014	UR Denial Date:	10/14/2014
Priority:	Standard	Application Received:	10/30/2014

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 & Rehabilitation and is licensed to practice in California. 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:

The injured worker is a 64 year old female who reported an injury on 03/30/2013 due to an unspecified mechanism of injury. The diagnoses included right radial styloid tenosynovitis (aka de Quervain's syndrome), bilateral wrist/hand tendinitis, bilateral wrist/hand pain, left forearm pain status post scaphoid resection and 4 quadrant fusions dated 01/13/2013, and chronic pain related to insomnia and neuropathic pain. The injured worker complained of bilateral wrist, hand, and shoulder pain she rated a 5/10 with medication and 8/10 without medication. Objective findings, dated 10/14/2014, revealed blood pressure of 120/80, pulse 60, and respirations 14. Past treatments included physical therapy, medication, and cortisone injection. Past treatments also included a CT scan, x-rays, and an MRI. The treatment plan included a retrospective urine drug screen, Percura, and topical analgesic. The request for authorization was not submitted with documentation. Rationale was not provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective request for urine drug screen for the service date of 10/02/14: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Drug Screen Page(s): 43.

Decision rationale: The retrospective request for urine drug screen for the service date of 10/02/14 is not medically necessary. The California MTUS Guidelines recommend urine drug screen tests as an option to assess for the use or presence of illegal drugs. It may also be used in conjunction with a therapeutic trial of opiates, On-ongoing management, and as a screen for risk of misuse and addiction. The clinical notes, dated 02/11/2014, revealed a positive drug screen for codeine. The clinical notes indicate the injured worker has had several drug screens, including a drug screen for 10/02/2014. There was no documentation provided to indicate that the injured worker displays any aberrant behaviors or drug seeking behavior or whether the injured worker is suspected of illegal drug use to warrant repeated drug screens. There is no evidence of drug use or narcotic use not prescribed. As such, the request is not medically necessary.

Percura #120: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Medscape:
<http://reference.medscape.com/drug/percura-amino-acids-mixture-999793> and Official Disability Guidelines (ODG): Medical Foods

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

Decision rationale: The request for Percura #120 is not medically necessary. The Official Disability Guidelines state that there is no indication for the use of this product until there are high quality studies of the ingredients of Percura; it is not recommended. The request did not indicate the dosage or frequency. As such, the request is not medically necessary.

Neuro-relief formula ointment 20%/Flurbiprofen/Baclofen/Cyclobenzaprine 2%/Gabapentin 6%/Lidocaine 2.5%: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics. Decision based on Non-MTUS Citation Food and Drug Administration (FDA): http://leginfo.ca.gov/pub/11-12/bill/asm/ab_0351-0400/ab_378_bill_20110908_amended_sen_v94.html.

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

Decision rationale: The request for neuro-relief formula ointment, 20% Flurbiprofen/Baclofen/Cyclobenzaprine 2%/Gabapentin 6%/Lidocaine 2.5% is not medically necessary. The California MTUS guidelines state that transdermal compounds are largely experimental in use with few randomized trials recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least 1 drug that is not recommended is not recommended. The guidelines note that gabapentin is not

recommended as a topical application. Additionally, the request did not specify the frequency, dosage, or duration. As such, the request is not medically necessary.