

Case Number:	CM15-0111005		
Date Assigned:	06/17/2015	Date of Injury:	10/18/2008
Decision Date:	08/17/2015	UR Denial Date:	05/26/2015
Priority:	Standard	Application Received:	06/09/2015

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: Emergency 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 38-year-old female who sustained an industrial injury on 10/18/08. The injured worker was diagnosed as having overuse syndrome right upper extremity, carpal tunnel syndrome right wrist, de Quervain's tendinitis right wrist, cubital tunnel syndrome right elbow, and lateral epicondylitis right elbow. Currently, the injured worker was with complaints of right upper extremity discomfort. Previous treatments included medication management and activity modification. Physical examination was notable for tenderness over the carpometacarpal joint and right thumb. The plan of care was for medication prescriptions.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ibuprofen 800mg #90 with 5 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pg. 22, Anti-inflammatory medications Page(s): 22.

Decision rationale: The requested Ibuprofen 800mg #90 with 5 refills is not medically necessary. California's Division of Worker's Compensation "Medical Treatment Utilization Schedule" (MTUS), Chronic Pain Medical Treatment Guidelines, Pg. 22, Anti-inflammatory medications note "For specific recommendations, see NSAIDs (non-steroidal anti-inflammatory drugs). Anti-inflammatories are the traditional first line of treatment, to reduce pain so activity and functional restoration can resume, but long-term use may not be warranted." The injured worker has right upper extremity discomfort. Previous treatments included medication management and activity modification. Physical examination was notable for tenderness over the carpometacarpal joint and right thumb. The treating physician has not documented current inflammatory conditions, duration of treatment, derived functional improvement from its previous use, nor hepatorenal lab testing. The criteria noted above not having been met, Ibuprofen 800mg #90 with 5 refills is not medically necessary.

Fioricet #20 (unspecified dose): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Barbiturate-containing analgesic agents.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-Going Management, Pages 78-80, Opioids for Chronic Pain, Pages 80-82 and p. 23 "Barbiturate-containing analgesic agents (BCAs)" Page(s): 78-82, 23.

Decision rationale: The requested Fioricet #20 (unspecified dose), is not medically necessary. CA MTUS Chronic Pain Treatment Guidelines, Opioids, On-Going Management, Pages 78-80, Opioids for Chronic Pain, Pages 80-82, recommend continued use of this opiate for the treatment of moderate to severe pain, with documented objective evidence of derived functional benefit, as well as documented opiate surveillance measures. CA MTUS Chronic Pain Treatment Guidelines, p. 23 "Barbiturate-containing analgesic agents (BCAs)" not recommended for chronic pain. The injured worker has right upper extremity discomfort. Previous treatments included medication management and activity modification. Physical examination was notable for tenderness over the carpometacarpal joint and right thumb. The treating physician has not documented VAS pain quantification with and without medications, duration of treatment, objective evidence of derived functional benefit such as improvements in activities of daily living or reduced work restrictions or decreased reliance on medical intervention, nor measures of opiate surveillance including an executed narcotic pain contract or urine drug screening; nor medical necessity specifically for a barbiturate-containing medication as an outlier to referenced negative guideline recommendations. The criteria noted above not having been met, Fioricet #20 (unspecified dose) is not medically necessary.

Repeat MRI of the cervical spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 182. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), MRI.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178-179.

Decision rationale: The requested Repeat MRI of the cervical spine is not medically necessary. CA MTUS, ACOEM 2nd Edition, 2004, Chapter 8, Neck and Upper Back Complaints, Special Studies and Diagnostic and Therapeutic Considerations, Pages 178-179, recommend imaging studies of the cervical spine with "Unequivocal objective findings that identify specific nerve compromise on the neurological examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option". The injured worker has right upper extremity discomfort. Previous treatments included medication management and activity modification. Physical examination was notable for tenderness over the carpometacarpal joint and right thumb. The treating physician has not documented a history of acute trauma, nor physical exam evidence indicative of radiculopathy such as a Spurling s sign or deficits in dermatomal sensation, reflexes or muscle strength, nor evidence of an acute clinical change since a previous imaging study. The criteria noted above not having been met, Repeat MRI of the cervical spine is not medically necessary.

Zolpidem 10mg #30 with 4 refills: 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), Zolpidem (Ambien).

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), (updated 07/10/14), Insomnia Medications.

Decision rationale: The requested Zolpidem 10mg #30 with 4 refills is not medically necessary. CA MTUS is silent. Official Disability Guidelines, Pain (Chronic), Insomnia Medications note "Zolpidem is a prescription short-acting non-benzodiazepine hypnotic, which is approved for the short-term (usually two to six weeks) treatment of insomnia". The injured worker has right upper extremity discomfort. Previous treatments included medication management and activity modification. Physical examination was notable for tenderness over the carpometacarpal joint and right thumb. The treating physician has not documented current sleep disturbance, results of sleep behavior modification attempts or any derived functional benefit from its previous use. The criteria noted above not having been met, Zolpidem 10mg #30 with 4 refills is not medically necessary.