

Case Number:	CM15-0112566		
Date Assigned:	06/19/2015	Date of Injury:	01/02/2007
Decision Date:	07/20/2015	UR Denial Date:	05/22/2015
Priority:	Standard	Application Received:	06/11/2015

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: Physical Medicine & Rehabilitation, Pain Management

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 57 year old female, who sustained an industrial injury on January 2, 2007. She reported intractable left shoulder pain and bilateral wrist pain. The injured worker was diagnosed as having bilateral carpal tunnel syndrome, bilateral carpal tunnel release and revision and calcific tendonitis, left shoulder internal derangement and chronic pain syndrome with chronic opioid tolerance. Treatment to date has included radiographic imaging, diagnostic studies, surgical interventions on bilateral wrists, extensive physical therapy, medications and work restrictions. Currently, the injured worker complains of continued left shoulder pain and bilateral wrist pain with associated hand and finger pain and numbness. The injured worker reported an industrial injury in 2007, resulting in the above noted pain. She was treated conservatively and surgically without complete resolution of the pain. Evaluation on March 30, 2015, revealed continued pain as noted. She reported having difficulty with activities of daily living and reported requiring medications to remain functional. A functional restoration program and topical medications were requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

Flurbiprofen POW 240gms: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113 of 127.

Decision rationale: Regarding the request for flurbiprofen POW, it appears that the provider intends to prescribe topical fluriprofen and lidocaine. CA MTUS states that topical compound medications require guideline support for all components of the compound in order for the compound to be approved. Topical NSAIDs are indicated for "Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment: Recommended for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. Neuropathic pain: Not recommended as there is no evidence to support use." Topical lidocaine is "Recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica)." Additionally, it is supported only as a dermal patch. Within the documentation available for review, none of the abovementioned criteria have been documented. Given all of the above, the requested flurbiprofen POW is not medically necessary.

Functional restoration programs: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Functional Restoration Programs. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Procedure Summary - Online Version - Criteria for general use of multidisciplinary pain management programs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 30-34 and 49 of 127.

Decision rationale: Regarding the request for a functional restoration program, California MTUS supports chronic pain programs/functional restoration programs when: Previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement; The patient has a significant loss of ability to function independently resulting from the chronic pain; The patient is not a candidate where surgery or other treatments would clearly be warranted; The patient exhibits motivation to change, and is willing to forgo secondary gains, including disability payments to effect this change; & Negative predictors of success have been addressed. Within the medical information available for review, there is no indication that there are no other treatment options available and it appears that additional interventional treatment and follow-up with orthopedics has been recommended. Additionally, there is no discussion regarding motivation to change and negative predictors of success. Furthermore, while it appears that the provider intends to request a consultation for an FRP, the request as cited is for a functional restoration program rather than a consultation and, unfortunately, there is no provision for modification of the current request. In the absence of clarity regarding the above issues, the currently requested functional restoration program is not medically necessary.