

<b>Case Number:</b>	CM15-0027778		
<b>Date Assigned:</b>	02/20/2015	<b>Date of Injury:</b>	09/12/2012
<b>Decision Date:</b>	06/11/2015	<b>UR Denial Date:</b>	01/21/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/13/2015

### 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: Preventive Medicine, Occupational Medicine, Public Health & General Preventive 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 58 year old female, who sustained a work/ industrial injury on 9/12/12 as a typist clerk due to repetitive use of hands. She has reported symptoms of pain and swelling in the hands, wrists, and fingers. Pain was rated 8/10 in the right wrist and 5/10 in the left wrist. The diagnoses have included right wrist pain and dysfunction, right carpal tunnel syndrome, and bilateral hand skin irritation. Treatments to date included medications, drug screens, and chiropractic care. Diagnostics included an electromyogram that reported severe bilateral median sensory neuropathy at the wrists and median motor neuropathy at the wrists. Shoulder ultrasound noted right acromioclavicular joint degenerative disease, right rotator cuff tendinosis and bursitis. Magnetic Resonance Imaging (MRI) of cervical spine noted C3-4, C4-5, and C5-6 mild central spinal canal stenosis with disc protrusions and mild spondylosis at C4 through C7. MRI of the thoracic spine reported T2 hyper intensity in the T3 spinous process and multilevel thoracic spine spondylosis. Medications included Tramadol, Naproxen, Omeprazole, and Methoderm ointment. Per examination on 11/12/14, there was decreased range of motion of the right wrist, tenderness to palpation, positive Tinel's and Phalen's tests. The treating physician requested continued chiropractic therapy, use of a volar wrist brace, a dermatology evaluation, and ergonomic chair, a follow up with a hand surgeon, and psychological consult. On 1/21/15, Utilization Review certified Tramadol 50mg to Tramadol 50 mg x 1 month and non-certified Naproxen 550mg; Omeprazole 20mg; Methoderm ointment; Ergonomic chair; Dermatology

evaluation; Psychological consult, noting the California Medical treatment Utilization Schedule (MTUS) Guidelines.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Tramadol 50mg:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic pain, ongoing management Page(s): 60, 78.

**Decision rationale:** The California MTUS guidelines recommend opiates for chronic pain. There should be documentation of an objective improvement in function, an objective decrease in pain, and evidence that the injured worker is being monitored for aberrant drug behavior and side effects. The clinical documentation submitted for review indicated the injured worker was being monitored for aberrant drug behavior through urine drug screens. There was however a lack of documentation of objective improvement in function, and objective decrease in pain, and documentation of side effects. The request as submitted failed to indicate the frequency for the requested medication and the quantity. Given the above, the request for Tramadol 50 mg is not medically necessary.

**Naproxen 550mg:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 67.

**Decision rationale:** The California MTUS guidelines indicate that NSAIDS are recommended for short term symptomatic relief of mild to moderate pain. There should be documentation of objective functional improvement and an objective decrease in pain. The clinical documentation submitted for review failed to provide documentation of objective functional improvement and objective decrease in pain. The request as submitted failed to indicate the frequency and quantity for the requested medication. Given the above, the request for naproxen 550 mg is not medically necessary.

**Omeprazole 20mg:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 69.

**Decision rationale:** The California MTUS guidelines recommend proton pump inhibitors for injured workers at intermediate risk or higher for gastrointestinal events and are also for the treatment of dyspepsia secondary to NSAID therapy. The clinical documentation submitted for review failed to provide the injured worker was at intermediate or high risk for gastrointestinal events. The rationale for the use of the medication was not provided. As the NSAID was found to be not medically necessary, the Omeprazole would not be medically necessary. The request as submitted failed to indicate the frequency and quantity. Given the above, the request for Omeprazole 20 mg is not medically necessary.

**Menthoderm ointment:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, Topical Salicylates Page(s): 111, 105.

**Decision rationale:** The California Medical Treatment Utilization Schedule guidelines indicate 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. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. They further indicate that topical salicylates are appropriate for the treatment of pain. The clinical documentation submitted for review failed to provide documentation of an antidepressant and anticonvulsant that had failed. The request as submitted failed to indicate the frequency, quantity, and body part to be treated. Given the above, the request for Menthoderm ointment is not medically necessary.

**Ergonomic chair:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 1 Prevention.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg Chapter, Durable Medical Equipment.

**Decision rationale:** The Official Disability Guidelines indicate that durable medical equipment is recommended when there is a medical need and if the device or system meets Medicare's definition of durable medical equipment which includes: can withstand repeated use, as in could normally be rented and used by successive patients; is primarily and customarily used to serve a medical purpose; and is generally not useful to an injured worker in the absence of illness or injury. The clinical documentation submitted for review failed to meet the above criteria. A chair would not be considered durable medical equipment as it can be used in the absence of

illness or injury. As such it would not be covered. Given the above, the request for ergonomic chair is not medically necessary.

**Dermatology evaluation:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM for Independent Medical Examinations and Consultations regarding Referrals, Chapter 7.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Introduction Page(s): 1.

**Decision rationale:** The California Medical Treatment Utilization Schedule guidelines recommend upon ruling out a potentially serious condition, conservative management is provided. If the complaint persists, the physician needs to reconsider the diagnosis and decide whether a specialist evaluation is necessary. The clinical documentation submitted for review failed to provide a rationale for the dermatology consultation. Without the rationale, this request would not be supported. Given the above, the request for dermatology evaluation is not medically necessary.

**Psychological consult:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Ongoing Management Page(s): 78.

**Decision rationale:** The California MTUS guidelines recommend consideration of a psych consult if there is evidence of depression, anxiety or irritability. The clinical documentation submitted for review failed to provide documented rationale for the request. There was a lack of documentation of objective signs of depression, anxiety, or irritability, and there was a lack of documentation of subjective complaints. Given the above, the request for psych consult is not medically necessary.