

Case Number:	CM15-0037284		
Date Assigned:	03/05/2015	Date of Injury:	02/09/2012
Decision Date:	06/02/2015	UR Denial Date:	02/05/2015
Priority:	Standard	Application Received:	02/27/2015

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 52-year-old female who reported an injury on 02/08/2012. The specific mechanism of injury was not provided. The injured worker is currently diagnosed with right shoulder internal derangement, right hand carpal tunnel syndrome, cervical spine sprain with radiculopathy, anxiety, depression, and insomnia. The latest physician progress report submitted for this review is documented on 08/12/2014. The injured worker presented for a follow-up evaluation with complaints of 7/10 right shoulder pain with a loss of motion, 4/10 hand pain with numbness near the carpal tunnel incision, and 7/10 cervical spine pain with tingling, radiating pain, and stiffness. Anxiety and depression were reportedly increased. Upon examination of the right shoulder, there was 90-degree forward flexion, 100-degree abduction, 70-degree external rotation, 80-degree internal rotation, 35-degree extension, tenderness, and positive crepitus. Examination of the cervical spine also revealed limited range of motion with tenderness and spasm. Examination of the right upper extremity revealed tenderness at the lateral epicondyle with decreased sensation in the C5-8 dermatome. Recommendations included continuation of the prescribed topical compounded creams, a follow-up evaluation for the right hand and shoulder, and a pain management evaluation. There was no Request for Authorization form submitted for this review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Urine toxicology testing: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 43, 77, 89. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter, Urine Drug Testing.

Decision rationale: The California MTUS Guidelines state drug testing is recommended as an option, using a urine drug screen to assess for the use or presence of illegal drugs. The Official Disability Guidelines state the frequency of urine drug testing should be based on documented evidence of risk stratification. Patients at low risk of addiction or aberrant behaviors should be tested within 6 months of initiation of therapy and on a yearly basis thereafter. As per the clinical notes submitted, there is no mention of noncompliance or misuse of medication. There is no indication that this injured worker falls under a high-risk category that would require frequent monitoring. Therefore, the current request is not medically necessary.

Topical compounds and creams, quantity and strength unspecified: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Topical Analgesics Page(s): 111. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain, Compound drugs.

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

Decision rationale: The California MTUS Guidelines state any compounded product that contains at least 1 drug that is not recommended is not recommended as a whole. The specific type of compounded cream was not listed in the request. The quantity, strength, and frequency were unspecified. Given the above, the request is not medically necessary.

Consultation with a pain management specialist for evaluation: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 127.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 89-92.

Decision rationale: The California MTUS/ACOEM Practice Guidelines state a referral may be appropriate if the practitioner is uncomfortable with the line of inquiry outlined above, with treating a particular cause of delayed recovery, or has difficulty obtaining information or agreement to a treatment plan. There is no documentation of an exhaustion of conservative

management. The medical rationale for a pain management specialist was not documented. As the medical necessity has not been established, the request is not medically necessary.

Interferential unit, 3 month rental: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 120.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 117-121.

Decision rationale: The California MTUS Guidelines state that interferential current stimulation is not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise, and medications. There should be documentation that pain is ineffectively controlled due to the diminished effectiveness of medications or side effects, a history of substance abuse, or significant pain from postoperative conditions. In this case, it is noted that the injured worker is currently utilizing an H-Wave stimulator. The medical necessity for an interferential unit has not been established. There is also no documentation of a successful 1-month trial prior to the request for a 3-month rental. Given the above, the request is not medically necessary.

Ambien 10mg, quantity unspecified: 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), Pain, 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) Chronic Pain Chapter, Insomnia Treatment.

Decision rationale: The Official Disability Guidelines recommend insomnia treatment based on etiology. Ambien is indicated for the short-term treatment of insomnia with difficulty of sleep onset for 7 to 10 days. The injured worker does maintain a diagnosis of insomnia disorder. However, there was no documentation of an attempt at non-pharmacologic treatment prior to the initiation of a prescription product. There is also no frequency or quantity listed in the request. As such, the request is not medically necessary.