

Case Number:	CM15-0061950		
Date Assigned:	04/07/2015	Date of Injury:	03/13/2014
Decision Date:	06/01/2015	UR Denial Date:	03/23/2015
Priority:	Standard	Application Received:	04/01/2015

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, Washington

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 47 year old male, who sustained an industrial injury on March 13, 2014. The injured worker reportedly suffered a left forearm fracture when his left hand was caught in a machine. Diagnoses have included left radial and ulnar fracture, left shoulder strain/sprain, crush injury of the forearm, left wrist strain/sprain, and left hand joint pain. Treatment to date has included medications, wrist surgery, casting, home exercise, and imaging studies. A progress note dated March 18, 2015 indicates a chief complaint of stiffness, numbness, tingling, weakness and pain of the left shoulder, left forearm, and left wrist, and numbness of the left hand. Upon examination of the left forearm, there was diminished supination and pronation to 60 degrees with tenderness to palpation over the dorsal and radial forearm. Examination of the left wrist and hand also revealed limited range of motion with tenderness to palpation over the dorsal wrist, positive Froment's paper test, and painful Phalen's and carpal compression test. Treatment recommendations included continuation of the current medication regimen, paraffin was therapy for the left hand, and physical therapy for the left upper extremity. There was no Request for Authorization form submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tramadol ER 100mg #45: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

Decision rationale: The California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of nonopioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. In this case, the injured worker has continuously utilized the above medication since at least 12/2014. There is no documentation of objective functional improvement. There is also no frequency listed in the request. As such, the request is not medically necessary.

Gabapentin 10%/Amitriptyline 10%/Bupivacaine 5% QTY: 1.00: Upheld

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

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 one drug that is not recommended, is not recommended as a whole. Gabapentin is not recommended, as there is no peer reviewed literature to support its use as a topical product. There is also no frequency listed in the request. As such, the request is not medically necessary.

Flurbiprofen 20%/Baclofen 10%/Dexamethasone 2% QTY: 1.00: Upheld

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

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 one drug that is not recommended, is not recommended as a whole. The only FDA-approved topical NSAID is diclofenac. The request for a compounded cream containing flurbiprofen would not be supported. Muscle relaxants are not recommended for topical use. There is also no frequency listed in the request. As such, the request is not medically necessary.

Paraffin wax therapy 2x6 for left hand weakness, QTY: 12.00: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines - Forearm, Wrist, & Hand Chapter; Paraffin Wax Baths.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 59, 98-99.

Decision rationale: The California MTUS Guidelines state the use of active treatment modalities instead of passive treatments is associated with a substantially better clinical outcome. Passive therapy can provide short term relief during the early phases of pain treatment and is directed at controlling symptoms such as pain, inflammation, and swelling. They can be used sparingly with active therapy to help control swelling, pain, and inflammation during the rehabilitation process. The injured worker has objective evidence of limited range of motion of the left hand and wrist. However, there is no evidence of swelling or inflammation. There is no documentation of osteoarthritis. The medical necessity for the requested passive treatment has not been established in this case. As such, the request is not medically necessary.