

<b>Case Number:</b>	CM14-0148866		
<b>Date Assigned:</b>	09/18/2014	<b>Date of Injury:</b>	01/13/2014
<b>Decision Date:</b>	10/21/2014	<b>UR Denial Date:</b>	08/23/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/12/2014

### 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. The expert reviewer is Board Certified in Anesthesiology/Pain Medicine and is licensed to practice in Florida. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 40-year-old female who reported an injury on 01/13/2014. The mechanism of injury is from repetitive motion. The diagnoses included cumulative trauma from repetitive motion, hand injury, neuropathy, lateral epicondylitis, de Quervain's tenosynovitis, and left shoulder pain. The previous treatments included medication, TENS Unit, and EMG/NCV. Within the clinical note dated 09/12/2014, it was reported the injured worker complained of left wrist pain, left shoulder pain. She rated her pain 7/10 in severity. She complained of left sided cervical pain associated a pulling sensation. Upon the physical examination, the provider noted decreased range of motion of the left wrist with flexion. Pain was noted to be elicited with radial deviation. There was decreased sensation and decreased motor strength rated 3/5. The provider requested Ibuprofen, Docuprene, Mentherm ointment. However, a rationale was not submitted for clinical review. The Request for Authorization was submitted and dated on 09/12/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Ibuprofen 800mg #100:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Ibuprofen Page(s): 72.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs), Page(s): 66-67.

**Decision rationale:** The request for Ibuprofen 800 mg #100 is not medically necessary. The California MTUS Guidelines recommend non-steroidal anti-inflammatory drugs at the lowest dose for the shorted period of time. The guidelines note NSAIDs are recommended for signs and symptoms of osteoarthritis. The request submitted failed to provide the frequency of the medication. There is lack of documentation indicating the medication had been providing objective functional benefit and improvement. Therefore, the request is not medically necessary.

**Docuprene 100mg #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use, Page(s): 77.

**Decision rationale:** The request for Docuprene 100 mg #60 is not medically necessary. The California MTUS Guidelines state that when initiating opioid therapy, prophylactic treatment for constipation should be initiated. There is no indication indicating the injured worker did not respond well to the opioid treatment. The request submitted failed to provide the frequency of the medication. Additionally, there is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. Therefore, the request is not medically necessary.

**Menthoderm Ointment 120mg:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Menthoderm Page(s): 111.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical NSAIDs, Page(s): 111-112.

**Decision rationale:** The request for Menthoderm ointment 120 grams is not medically necessary. The California MTUS Guidelines recommend topical NSAIDs for osteoarthritis and tendinitis, in particular that of the knee and/or elbow and other joints that are amenable. Topical NSAIDs are recommended for short term use of 4 to 12 weeks. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. Additionally, the request submitted failed to provide the treatment site. Therefore, the request is not medically necessary.