

<b>Case Number:</b>	CM13-0012632		
<b>Date Assigned:</b>	03/10/2014	<b>Date of Injury:</b>	01/27/2006
<b>Decision Date:</b>	10/23/2014	<b>UR Denial Date:</b>	08/09/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/12/2013

### 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 Family Medicine and is licensed to practice in Arizona. 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 patient is a 42 year old female with a date of injury on 1/27/2006. Diagnoses include lumbar degenerative disc disease with radiculopathy, right carpal tunnel syndrome, shoulder pain, and myofascial pain syndrome. Subjective complaints are of right arm pain. Physical exam showed reflexes were normal in the arms. There was a positive Phalen's and Tinel's sign, no atrophy and reasonable grip strength. Electrodiagnostic studies from 3/29/13 were normal. Prior treatment has included physical therapy, rest, medication, injections and splinting.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Right carpal tunnel release by [REDACTED]:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hand/Wrist, Carpal Tunnel Release.

**Decision rationale:** The ODG has specific criteria for consideration of carpal tunnel release surgery. These criteria include: Muscle atrophy, hand weakness, failure of conservative therapy, and positive electrodiagnostic studies. For this patient, submitted documentation shows normal

electrodiagnostic studies, and physical exam does not demonstrate atrophy or weakness. Therefore, the medical necessity for a carpal tunnel release surgery is not established at this time.

**Chronic pain physical therapy x 6 sessions:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hand/Wrist, Physical Therapy.

**Decision rationale:** The ODG recommends 1-3 visits over 3-5 weeks for carpal tunnel syndrome. Submitted documentation indicates that the patient has had previous conservative treatment, including physical therapy. The duration and outcomes of these prior therapy sessions are not identified in the documentation. Documentation is not present that indicates specific deficits for which additional formal therapy may be beneficial at this point in the patient's treatment. Therefore, the medical necessity for 6 physical therapy sessions is not established.

**Medication refills: Flexeril, Lidoderm Patches, Flector Patches:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics and Cyclobenzaprine Page(s): 111-113, 41-42.

**Decision rationale:** CA MTUS guidelines indicate that the use of cyclobenzaprine should be used as a short term therapy, and the effects of treatment are modest and may cause adverse affects. This patient had been using chronically, which is longer than the recommended course of therapy of 2-3 weeks. There is no evidence in the documentation that suggests the patient experienced improvement with the ongoing use of cyclobenzaprine. Due to clear guidelines suggesting cyclobenzaprine as short term therapy and no clear benefit from adding this medication the requested prescription for cyclobenzaprine is not medically necessary. CA MTUS recommends Lidoderm as a second line treatment for localized peripheral pain after there has been evidence of first line therapy treatment failure. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than post-herpetic neuralgia. The submitted documentation does not provide evidence for post-herpetic neuralgia or signs and symptoms consistent with neuropathic pain. Furthermore, Lidoderm is only recommended after a trial of a first-line medication such as a tricyclic drug. There is no trial of a first line medication evident in the medical records. Therefore, the medical necessity of Lidoderm patches is not established. CA MTUS indicates that topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but with a diminishing effect over another 2-week period. CA MTUS also indicates that topical NSAIDs are not recommended for neuropathic pain as there is no evidence to support their use, but does indicate

that they are recommended for osteoarthritis and tendinitis. For this patient, there is not documentation of osteoarthritis or tendinitis. Therefore, the medical necessity for Flector patches is not established.