

<b>Case Number:</b>	CM13-0015864		
<b>Date Assigned:</b>	12/11/2013	<b>Date of Injury:</b>	03/23/2013
<b>Decision Date:</b>	02/10/2014	<b>UR Denial Date:</b>	08/09/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/23/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Occupational Medicine and is licensed to practice in California. 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 physician 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 40-year-old male who sustained a work-related injury to his right wrist and low back on 3/23/13. MRI of the lumbar spine on 7/15/13 reveals disc bulge at L2-L4 with mild central canal narrowing and mild facet hypertrophy. Treatment included 6 sessions of PT, 4 sessions of aquatic therapy, lumbar cortisone injection, lumbar and wrist supports, and meds consistent of muscle relaxants, anti-inflammatory and analgesics. PTP PR2 on 7/25/13 reveals patient complains of lumbar spine sharp throbbing pain 5-6/10 decreases to 2/10 with meds with pain radiation to the left lower extremity. He complained of pinching and throbbing right wrist pain. Exam findings reveals antalgic gait, favors left lower extremity, minimal tenderness to palpation of the paracervical, trapezius, rhomboids and shoulders bilaterally, decreased lumbar ranges of motion with tenderness and spasm of the lumbosacral and SI joints, left more than right, sciatic notch tenderness bilaterally, (+)SLR on left seated to 70 and supine to 60 degrees, slight diminished muscle strength of the left lower extremity. There was swelling of the right radial forearm and wrist and over the first MCP joint with tenderness to palpation of the anatomical snuffbox and decreased ranges of motion of the right wrist with Tinel's and carpal compression test positive, decreased right wrist strength and decreased right thumb abduction/extension and right grip strength. Diagnosis is back ache and degenerative disc disease. PTP PR2 on 8/21/13 notes patient has low back pain left greater than right and right wrist pain at rest. MRI right wrist on 8/23/13 reveals Extensor carpi radialis long and brevis tendinopathy and tenosynovitis, mild extensor carpi ulnaris tendinopathy and focal subchondral sclerosis medial margin of proximal lunate articular surface. The patient was started on Acupuncture x 4 sessions on 8/28/13.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical Therapy 2 x 4 weeks: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines physical medicine Page(s): 98.

**Decision rationale:** The Physician Reviewer's decision rationale: CA MTUS addresses physical medicine. It allows for fading treatment 8-10 sessions, depending on issue being treated. In this case, the patient has had 6 sessions of passive PT and 4 sessions of aquatic therapy. There is no specific notation in the records of the patient's improvement in regards to pain and function with the previous therapy. Additional therapy may be appropriate if it is documented the original treatment has helped the patient. With current information, it does not appear the 10 sessions the patient already had showed significant improvement. Therefore, the 6 sessions requested are not necessary.

**Cognitive Behavioral Therapy evaluation x 1: Overturned**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines behavioral intervention. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Cognitive Behavioral Therapy (CBT) guidelines for chronic pain

**Decision rationale:** Recommended. The identification and reinforcement of coping skills is often more useful in the treatment of pain than ongoing medication or therapy, which could lead to psychological or physical dependence. See also Multi-disciplinary pain programs.

**Transcutaneous electrical nerve stimulation (TENS), one month trial: Overturned**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS Page(s): 116.

**Decision rationale:** Documentation of pain of at least three months duration- There is evidence that other appropriate pain modalities have been tried (including medication) and failed- A one-month trial period of the TENS unit should be documented (as an adjunct to ongoing treatment modalities within a functional restoration approach) with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function; rental would be preferred over purchase during this trial - Other ongoing pain treatment should also be documented during the

trial period including medication usage - A treatment plan including the specific short- and long-term goals of treatment with the TENS unit should be submitted - A 2-lead unit is generally recommended; if a 4-lead unit is recommended, there must be documentation of why this is necessary.

**Magnetic resonance imaging (MRI) of right wrist:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 268.

**Decision rationale:** CA MTUS states that MRI may be appropriate if there are red flags in history or exam. This patient had "There was swelling of the right radial forearm and wrist and over the first MCP joint with tenderness to palpation of the anatomical snuffbox and decreased ranges of motion of the right wrist with Tinel's and carpal compression test positive, decreased right wrist strength and decreased right thumb abduction/extension and right grip strength." The tenderness in the snuff box and decreased ROM warranted additional imaging. Therefore, it is appropriate.

**Prednisone 3/day:** 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).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), low back, corticosteroids.

**Decision rationale:** The Physician Reviewer's decision rationale: CA MTUS does not address oral corticosteroids. ODG states that corticosteroids should only be used for acute radicular pain and not chronic pain. There is no clear evidence given in the RFA progress note as to the need for prednisone. The patient has not been exhibiting symptoms of radiculopathy and the progress note states additional studies are needed to evaluate for radiculopathy. As guides do not recommend prednisone for acute pain, it is not necessary.

**Naproxen, 1 bid:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAID Page(s): 68.

**Decision rationale:** The Physician Reviewer's decision rationale: The patient has been taking NSAIDs for low back pain. MTUS only recommends NSAIDS for a short period of time. First line treatment is acetaminophen which there is no documentation of a trial. Therefore a continued long term use of NSAIDs is not recommended within MTUS. Therefore, the NSAID is not appropriate.

**Acetaminophen 500mg, qid:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Acetaminophen Page(s): 11.

**Decision rationale:** The Physician Reviewer's decision rationale: CA MTUS recommends Acetaminophen (APAP) as a first line treatment for chronic pain. This patient has chronic low back pain and wrist pain. This treatment is therefore appropriate. Caution should be used however to make sure the patient uses appropriate amounts of the medication due to risk of side-effects and toxicity.

**Orphenadrine:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines muscle relaxants Page(s): 65.

**Decision rationale:** The Physician Reviewer's decision rationale: CA MTUS does not recommend muscle relaxants for long term treatment of chronic pain. There is no evidence that the patient suffers from muscle spasm. Therefore as a pain reliever muscle relaxants are not recommended for prolonged treatment, and therefore this medication is not currently necessary.

**Gabapentin 600mg, qhs:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines AEDs Page(s): 16.

**Decision rationale:** The Physician Reviewer's decision rationale: AEDs are recommended for neuropathic pain that is pain from nerve damage. There is no evidence of neuropathic pain in this patient. Also a trial of AEDs needs to include documentation of response. There is no response to this medication noted in the record. There needs to be at least a 30-50% improvement in

symptoms. As this response is not noted and there it is not recommended for chronic pain in this case, the gabapentin is not recommended.

**. Norco 1 bid pm:** Upheld

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

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

**Decision rationale:** The Physician Reviewer's decision rationale: CA MTUS does not recommend long-term use of opioid medications for chronic low back pain. In addition, the documentation given by the provider does not indicate any functional improvement or reduction in pain. It does not show that the patient has had any improvement in his activities of daily living or reduced restrictions at work or return to work. Guidelines require documentation of these effects for this medication, especially for continued use. As his medications has been used for an extended period of time, these criteria are important to evaluate the efficacy of this medication. The treatment request is not meet guidelines and is therefore not necessary.