

Case Number:	CM13-0020335		
Date Assigned:	12/27/2013	Date of Injury:	12/03/2012
Decision Date:	02/28/2014	UR Denial Date:	08/22/2013
Priority:	Standard	Application Received:	09/05/2013

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 Physical Medicine & Rehabilitation, has a subspecialty in Pain Management 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:

This is a female patient with a date of injury of 12/3/12. A utilization review determination dated 8/22/13 recommends non-certification of MRI of right wrist, TENS, soft and rigid braces for right wrist, hot and cold wrap for right wrist, PT/chiropractic treatment x 12, corticosteroid injection to right wrist, tramadol ER, Prilosec, Gabapentin, Terocin lotion, and Medrox patch. Naproxen was certified. A progress report dated 8/1/13 identifies a history of right wrist sprain and ganglion cyst right wrist. Recommendations based on a P&S report from 12/3/12 were noted to be continued HEP, dorsal wrist splint during the day, and naproxen as needed with regular work duty. Fluoroscopy of the right wrist was said to show ulnar positive variants. Other treatment has included tramadol, 6 sessions of PT, and 18 sessions of acupuncture. Subjective complaints include intermittent right wrist pain 6/10 radiating to the fingers as well as weakness of the arm. The patient also reports symptoms of depression, gastrointestinal problems, trouble falling asleep, and waking up at night because of pain. She reports having some difficulty with repetitive motions such as typing. Objective examination findings identify weakness against resisted function to hand and fingers on the right. Sensation is diminished on the right greater than left upper extremity, although not along any particular dermatomal distribution. Reverse Phalen's negative. Hyperflexion test is equivocal. Tenderness on carpal tunnel bilaterally, mild on the left. Mild tenderness along the ulnar nerve was noted on the right. Diffuse discomfort along the left elbow. Tenderness along the lateral and medial epicondyle on the right, although not to stretch or resisted function on the right wrist. Roo's test equivocal. Mild tenderness along the wrist joint was noted. Watson test noted to be positive with a click on the right. There is tenderness along the palmar-ulnar joint. Diagnoses include medial and lateral epicondylitis on the right, although not to stretch or resisted function; ulnar nerve neuritis; wrist joint inflammation with possible ligamentous injury; diffuse discomfort along the left elbow,

nonspecific; element of stress, sleep dysfunction, and gastritis. Treatment plan recommends MRI of the right wrist including base of the thumb for further evaluation of ligamentous injury, in-home TENS unit, soft and rigid brace for the wrist, hot and cold wrap for the wrist pending clarification and coverage regarding the elbow, elbow sleeve and elbow extension brace, tramadol ER, Prilosec for upset stomach, naproxen, Gabapentin for neuropathic pain, Terocin lotion, Medrox patch, chiropractic treatment/physical therapy for the right upper extremity to improve ROM, function, and strength, corticosteroid injection in the wrist and elbow and MRI for further evaluation.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI of the right wrist including base of the thumb: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 268-269. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG);Forearm, Wrist, & Hand (Acute and Chronic)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 269.

Decision rationale: ACOEM Guidelines support imaging studies to clarify the diagnosis if the medical history and physical examination suggest specific disorders. Within the documentation available for review, the provider notes a desire to evaluate for ligamentous injury. This suspicion is supported by longstanding pain and tenderness as well as the presence of a positive Watson test, which is indicative of scapholunate ligament injury. In light of the above, the currently requested MRI of right wrist including base of the thumb is medically necessary.

TENS unit for in-home use: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 120-127.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines transcutaneous electrotherapy Page(s): 114-117.

Decision rationale: The MTUS Chronic Pain Guidelines do support a trial of TENS after failure of other conservative care in the management of chronic pain. However, a purchase of a TENS unit is supported only after a one-month rental/trial has shown improvement with pain and function, decreased medication usage, etc. Within the documentation available for review, there is no documentation of a successful trial of TENS. In light of the above issues, the currently requested TENS unit for in-home use is not medically necessary

Soft Brace for the right wrist: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 272.

Decision rationale: ACOEM Guidelines do support splinting as first-line conservative treatment for multiple wrist/hand conditions. Within the documentation available for review, there is documentation that the patient was given and is utilizing a wrist brace. There is no clear rationale identifying why that brace is inappropriate and/or why an additional brace is needed to treat the injury. In the absence of such documentation, the currently requested soft brace for right wrist is not medically necessary.

Rigid Brace for the right wrist: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 272.

Decision rationale: ACOEM Guidelines do support splinting as first-line conservative treatment for multiple wrist/hand conditions. Within the documentation available for review, there is documentation that the patient was given and is utilizing a wrist brace. There is no clear rationale identifying why that brace is inappropriate and/or why an additional brace is needed to treat the injury. In the absence of such documentation, the currently requested rigid brace for right wrist is not medically necessary.

Hot and cold wrap for right wrist: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation AJSM, 2004, 32 pages 251-261, and the CAMTUS/ODG multiple chapters.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 265. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Carpal Tunnel Syndrome Chapter, Cold packs and Heat therapy

Decision rationale: ACOEM and Official Disability Guidelines do support the use of simple heat/cold packs. However, more sophisticated treatment is not supported except in the first 7 days following surgical intervention. Within the documentation available for review, there is no documentation supportive of the need for specialized hot and cold wraps rather than simple heat/cold packs. In the absence of such documentation, the currently requested hot and cold wrap for right wrist is not medically necessary.

Physical therapy/chiropractic treatment x12: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 61-62.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy, on Physical Medicine Page(s): 58-60, 98-99.

Decision rationale: MTUS Chronic Pain Guidelines support additional treatment only in the presence of objective functional improvement from prior sessions and they note that "patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels." Within the documentation available for review, there is documentation of completion of 6 previous sessions, but there is no documentation of specific objective functional improvement with the previous sessions and the MTUS Guidelines support only up to 10 PT sessions for this injury. Furthermore, the MTUS Chronic Pain Guidelines do not support the use of chiropractic/manipulation in the treatment of forearm, wrist, and hand conditions. In light of the above issues, the currently requested physical therapy/chiropractic treatment x12 is not medically necessary.

Corticosteroid injection to the right wrist: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 48.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 272.

Decision rationale: ACOEM Guidelines support injections of corticosteroids for various conditions such as carpal tunnel syndrome, de Quervain's syndrome, tenosynovitis, or trigger finger, and they consider an injection optional in moderate cases of tendinitis. Within the documentation available for review, there is no documentation of any of the supported conditions. The patient has a pending MRI, which may better identify the pain generator such that the need for corticosteroid injection can be reevaluated after completion of the study. In light of the above issues, the currently requested corticosteroid injection to right wrist is not medically necessary.

Tramadol ER 150mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 119.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 75-79.

Decision rationale: MTUS Chronic Pain Guidelines note that due to high abuse potential, close follow-up is recommended with documentation of analgesic effect, objective functional improvement, side effects, and discussion regarding any aberrant use. Guidelines go on to

recommend discontinuing opioids if there is no documentation of improved function and pain. Within the documentation available for review, there is no indication that the tramadol is improving the patient's function or pain, no documentation regarding side effects, and no discussion regarding aberrant use. In the absence of such documentation, the currently requested tramadol is not medically necessary.

Prilosec 20mg #60: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 68-69.

Decision rationale: MTUS Chronic Pain Guidelines state that proton pump inhibitors are appropriate for the treatment of dyspepsia secondary to NSAID therapy or for patients at risk for gastrointestinal events with NSAID use. Within the documentation available for review, there is documentation that the patient is taking naproxen and is experiencing upset stomach, gastritis, and heartburn. In light of the above, the currently requested Prilosec is medically necessary.

Gabapentin 600mg #90: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs Page(s): 16-21.

Decision rationale: The MTUS Chronic Pain Guidelines state that antiepilepsy drugs are recommended for neuropathic pain. Within the documentation available for review, there are symptoms/findings consistent with a possible neuropathic component of the patient's pain and a trial of the medication appears appropriate. The documentation suggests that the patient has not utilized this medication previously. In light of the above, the currently requested Gabapentin is medically necessary.

Terocin Lotion 40z: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 117-119.

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

Decision rationale: The MTUS Chronic Pain Guidelines state that topical NSAIDs are indicated for "Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment: Recommended for short-term use (4-12 weeks).

There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. Neuropathic pain: Not recommended as there is no evidence to support use." That has not been documented. Topical lidocaine is "Recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as Gabapentin or Lyrica)." That has also not been documented. Furthermore, it is supported only as a dermal patch. Capsaicin is "Recommended only as an option in patients who have not responded or are intolerant to other treatments." That has also not been documented. In the absence of such documentation in the medical records provided for review, the currently requested Terocin lotion is not medically necessary.

Medrox patch #20: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 117-119.

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

Decision rationale: The MTUS Chronic Pain Guidelines state that topical NSAIDs are indicated for "Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment: Recommended for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. Neuropathic pain: Not recommended as there is no evidence to support use." That has not been documented. Capsaicin is "Recommended only as an option in patients who have not responded or are intolerant to other treatments." That has also not been documented. In the absence of such documentation in the medical records provided for review, the currently requested Medrox patch is not medically necessary.