

Case Number:	CM13-0032773		
Date Assigned:	12/06/2013	Date of Injury:	08/27/2012
Decision Date:	01/21/2014	UR Denial Date:	09/18/2013
Priority:	Standard	Application Received:	10/08/2013

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 Pain Management, has a subspecialty in Disability Evaluation 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 a 50 years old female who sustained injury to right shoulder in 8/27/12. Patient was stuck in an elevator and for 45 minutes tried to pull the doors of the elevator open. Underwent right shoulder arthroscopic surgery in 4/10/13. She has a history of hypertension, diabetes, hyperlipidemia and gastritis. She also now says she developed Carpal tunnel syndrome on the right side during the injury. EMG done on 4/7/12 should mild to Moderate Carpal tunnel with prolonged median motor and sensory latencies across the wrist. On 7/16/13, clinical notes indicate that patient was interested in having Carpal tunnel release surgery.

IMR ISSUES, DECISIONS AND RATIONALES

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

Carpal tunnel release surgery, outpatient: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 270, Chronic Pain Treatment Guidelines NSAIDs Page(s): 63 & 69, Postsurgical Treatment Guidelines. 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): 65 & 270.

Decision rationale: According to Occupational medicine Practice Guideline, (page 65 and 270) the initial treatment of mild Carpal Tunnel Syndrome (CTS) is splinting. When treating with a splint in CTS, scientific evidence supports the efficacy of neutral wrist splints. Splinting should be used at night, and may be used during the day, depending upon activity. Outcomes from carpal tunnel surgery justify prompt referral for surgery in moderate to severe cases, though evidence suggests that there is rarely a need for emergent referral. Thus, surgery should usually be delayed until a definitive diagnosis of CTS is made by history, physical examination, facilitate the diagnosis; however, the benefit from these injections is short-lived. Trigger finger, if significantly symptomatic, is probably best treated with a cortisone/anesthetic injection at first encounter, with hand surgery referral if symptoms persist after two injections by the primary care or occupational medicine provider. Occupational Medicine Practice Guidelines supports cortisone injections for carpal tunnel syndrome. According to treating physician note, "On November 7, 2012, due to the ongoing symptoms in the right hand, the patient underwent a nerve study, which was noted to be abnormal for right carpal tunnel syndrome. The doctor recommended surgical intervention, but told her that this was due to a separate injury and not related to the trapped elevator incident that occurred on August 27, 2012." The EMG/NCV results show evidence of mild to moderate carpal tunnel syndrome, of the right hand. According to the guidelines, outcomes from carpal tunnel surgery justify prompt referral for surgery in moderate to severe cases, though evidence suggests that there is rarely a need for emergent referral.

Anaprox DS 550mg, #60 (retrospective): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 270, Chronic Pain Treatment Guidelines NSAIDs Page(s): 63 & 69, Postsurgical Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs hypertension and renal function, specific drug list and adverse side effects Page(s): 69. Decision based on Non-MTUS Citation New England Journal of Medicine 2004.

Decision rationale: CA-MTUS (effective July 18 2009) page 69 of 127, regarding the use of NSAIDs NSAIDs can increase blood pressure by an average of 5 to 6 mm in patients with hypertension. They may cause fluid retention, edema, and rarely, congestive heart failure. (Sustained blood pressure elevation in the elderly is associated with increases in hemorrhagic stroke, congestive heart failure and ischemic cardiac events.) The risk appears to be higher in patients with congestive heart failure, kidney disease or liver disease. Normotensive patients: NSAIDs appear to have minimal effect on blood pressure in normotensive patients. (Laine, 2007). Hypertensive patients: All NSAIDs have the potential to raise blood pressure in susceptible patients. The greatest risk appears to occur in patients taking the following anti-hypertensive therapy: angiotensin-converting enzyme (ACE) inhibitors; angiotensin receptor blockers; beta blockers; or diuretics. In addition congestive heart failure may develop due to fluid retention. Patients with mild to moderate renal dysfunction: All NSAIDs are relatively contraindicated in patients with renal insufficiency, congestive heart failure, or volume excess (such as cirrhosis). Oral opioids are an option for treatment. This patient also has a history of

diabetes mellitus and hypertension, and NSAID is relatively contra-indicated because of the possibility of worsening hypertension and accelerating the development of kidney damage in a patient with diabetes mellitus. An earlier study published in the New England Journal of Medicine in 1994 looked at the connection between painkiller use and the development of End Stage Renal Disease [ESRD], i.e. kidney failure. It concluded: A cumulative dose of 5000 or more pills containing NSAIDs was also associated with an increased odds of ESRD (odds ratio, 8.8) therefore the request for Anaprox DS 550mg #60 is considered not medically necessary.

Prilosec 20mg, #60 (retrospective): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 270, Chronic Pain Treatment Guidelines Page(s): 63 & 69, Postsurgical Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Non-steroidal anti-inflammatory drug (NSAID) Page(s): 8.

Decision rationale: The initial treatment for this patient is to discontinue the NSAIDs as indicated above. There is no documentation that the symptoms of gastritis continued after removal of NSAIDs. Treating the gastritis at this point with Prilosec is not medically necessary.

Robaxin 750mg, #120: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 270, Chronic Pain Treatment Guidelines NSAIDs Page(s): 63 & 69, Postsurgical Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47, Chronic Pain Treatment Guidelines Muscle relaxant Page(s): 63.

Decision rationale: According to occupational medicine practice Guidelines, page 47, section on initial approaches to treatment Muscle relaxants (e.g. Robaxin) seem no more effective than NSAIDs for treating patients with musculoskeletal problems, and using them in combination with NSAIDs has no demonstrated benefit, although they have been shown to be useful as antispasmodics. Side effects including drowsiness have been reported in up to 30% of patients taking muscle relaxants. Muscle relaxants act on the central nervous system and have no effect on peripheral musculature. They may hinder return to function by reducing the patient's motivation or ability to increase activity. There is no documentation that this patient has muscle spasm as the etiology of her back pain. Therefore the request for Robaxin 750mg 3120 is not medically necessary.

Physical Therapy 6 sessions, right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 270, Chronic Pain Treatment Guidelines NSAIDs Page(s): 63 & 69, Postsurgical Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

Decision rationale: CA-MTUS (effective July 18 2009) page 11 of 127, regarding the post operative physical therapy If postsurgical physical medicine is medically necessary, an initial course of therapy may be prescribed. With documentation of functional improvement, a subsequent course of therapy shall be prescribed within the parameters of the general course of therapy applicable to the specific surgery. If it is determined that additional functional improvement can be accomplished after completion of the general course of therapy, physical medicine treatment may be continued up to the end of the postsurgical physical medicine period. . The Physical Medicine Guidelines allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. The patient had a total of 28 physical therapy sessions after surgery. There is no documentation of functional improvement. MTUS page 16 recommended 24 sessions of physical therapy over 8 weeks period. Therefore the request for additional 6 sessions of physical therapy is not medically necessary.

Ortho Stem, 4 two months rental and supplies: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 270, Chronic Pain Treatment Guidelines NSAIDs Page(s): 63 & 69, Postsurgical Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Independent self-management Page(s): 98 & 121, Postsurgical Treatment Guidelines Page(s): 5 & 7.

Decision rationale: CA-MTUS (Effective July 18, 2009) page 114 to 121 of 127, The OrthoStim4 unit prescribed for this patient is a multi-modality unit containing neuromuscular electrical stimulation as well as interferential current therapy. Neuromuscular electrical stimulation (NMES) is specifically not recommended in the California MTUS. NMES is used primarily as part of a rehabilitation program following stroke and there is no evidence to support its use in chronic pain. There are no intervention trials suggesting benefit from NMES for chronic pain. (Moore, 1997) (Gaines, 2004) The scientific evidence related to electromyography (EMG)-triggered electrical stimulation therapy continues to evolve, and this therapy appears to be useful in a supervised physical therapy setting to rehabilitate atrophied upper extremity muscles following stroke and as part of a comprehensive PT program. Neuromuscular Electrical Stimulation Devices (NMES), NMES, through multiple channels, attempts to stimulate motor nerves and alternately causes contraction and relaxation of muscles, unlike a TENS device which is intended to alter the perception of pain. NMES devices are used to prevent or retard disuse atrophy, relax muscle spasm, increase blood circulation, maintain or increase range-of-motion,

and re-educate muscles. Functional neuromuscular stimulation (also called electrical neuromuscular stimulation and EMG-triggered neuromuscular stimulation) attempts to replace stimuli from destroyed nerve pathways with computer-controlled sequential electrical stimulation of muscles to enable spinal cord- injured or stroke patients to function independently, or at least maintain healthy muscle tone and strength. Also used to stimulate quadriceps muscles following major knee surgeries to maintain and enhance strength during rehabilitation. (BlueCross BlueShield, 2005) (Aetna, 2005). Therefore the request for Ortho-Stim4 (Surgi-Stim4) is not medically necessary