

<b>Case Number:</b>	CM13-0042915		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	05/14/2013
<b>Decision Date:</b>	09/05/2014	<b>UR Denial Date:</b>	10/14/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/21/2013

### 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 Orthopedic Surgery 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 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 55-year-old man, injured 05/14/13 with records indicating injury to the cervical spine, lumbar spine and right upper extremity. The recent clinical assessment of 09/05/13 describes continued complaints of pain about the aforementioned areas despite conservative care that has included medication management, formal physical therapy, work restrictions and chiropractic measures. The current complaints include neck pain with radiating hand and wrist discomfort with weakness to the hand. There is also low back pain with radiating pain to the right hip. The physical examination showed restricted cervical range of motion with equal and symmetrical reflexes and a hand examination that showed a step off from prior fifth metacarpal fracture that is well healed. Wrist examination was also with non-restricted dorsiflexion and volar flexion on the right with negative Tinel's testing, negative Finkelstein's testing but positive tenderness over the distal MP joint of the fifth metacarpal. Low back examination showed mildly restricted range of motion with equal and symmetrical reflexes, 5/5 motor strength and no sensory deficit. Working diagnosis was healed boxer's fracture to right fifth metacarpal, muscular ligamentous strain to the trapezius and cervical spine, a right hamstring strain. Recommendation at that time was for continuation of medications to include Tramadol, Cyclobenzaprine, Naprosyn and Omeprazole. There was also request for a functional capacity examination, continued physical therapy for the wrist, hand, cervical and lumbar spine and trapezius and an MR arthrogram of the right wrist and hand.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**PHYSICAL THERAPY FOR THE RIGHT WRIST/HAND, CERVICAL/LUMBAR SPINE AND RIGHT TRAPEZIUS MUSCULATURE: 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): 98-99.

**Decision rationale:** Based on the California MTUS chronic pain medical treatment guidelines, continued physical therapy would not be indicated. This individual has already undergone a significant course of underlying physical therapy and is with no current acute clinical findings on assessment. Given the amount of physical therapy already utilized since this individual's time of injury, the request for continuation of physical therapy for no specific quantity of sessions would not be indicated. As such, the request is not medically necessary.

**FUNCTIONAL CAPACITY EVALUATION: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic pain Page(s): 125-126.

**Decision rationale:** Based on the California MTUS chronic pain guidelines, a functional capacity examination would not be indicated. The Guidelines indicate functional capacity examinations are required to show consistent results with maximal effort demonstrating capacities to better assess with claimant's physical demand analysis. This individual is with no current documentation of a failed return to work attempt or indication of current clinic finding that would support the need for a functional capacity assessment. Without documentation of failed return to work attempts, there would be no current indication for use of an examination to demonstrate claimant's maximal effort. As such, the request is not medically necessary.

**OMEPRAZOLE 20MG: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Prilosec: : NSAIDs, GI symptoms & cardiovascular risk, page 68-69 Page(s): 68-69.

**Decision rationale:** The MTUS chronic pain guidelines would not support the use of Omeprazole. Presently, the use of protective Proton-Pump Inhibitors would require determination of a significant gastrointestinal event. This individual fails to meet any risk factor for GI event including age greater than 65 years, history of peptic ulcer, GI bleed or appropriation, concord use of Aspirin, corticosteroids or anticoagulants or multiple high dose

nonsteroidal usage. Without documentation of risk factor, the continued use of Omeprazole would not be supported. As such, the request is not medically necessary.

**NAPROXEN 550MG:** Upheld

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

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

**Decision rationale:** The MTUS Guidelines would not support the continued use of Naprosyn. At present, guidelines for use of nonsteroidal medication in the chronic setting indicate the lowest dose possible for the shortest period possible. This individual is currently showing no documentation of significant benefit with current medication regimen, particularly demonstrating no indication of improvement with use of nonsteroidal agents. Without documentation of acute clinical finding or symptom, the chronic use of Naprosyn in this individual would not be supported. As such, the request is not medically necessary.

**CYCLOBENZAPRINE 7.5 MG:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63.

**Decision rationale:** The MTUS Guidelines would not support continued use of Cyclobenzaprine. In regards to the chronic use of muscle relaxants, guidelines indicate that they should be utilized with caution as second line agents for acute exacerbations in individuals with chronic pain complaints. Records in this case indicate a stable clinical process with continued pain with no indication of acute clinical findings or indication of symptoms indicative of need of muscle relaxant treatment. The given the claimant's chronic clinical presentation, the acute role of muscle relaxants would not be supported. As such, the request is not medically necessary.

**TRAMADOL 325MG:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic pain; , Opioids-Classification-Tramadol (Ultram); Opioids-conditions-Tramadol (Ultram) Page(s): 91-94; 75; 80-84.

**Decision rationale:** The California MTUS Guidelines would not support the chronic use of Tramadol. The guideline criteria with use of Tramadol in the chronic setting indicates that its

efficacy is limited in that long-term efficacy beyond sixteen weeks is unclear. This individual has been utilizing this agent for a greater than sixteen week period. Without documentation of significant benefit or advancement of activities, the acute need of continuation of this drug would not be supported. As such, the request is not medically necessary.

**MR ARTHROGRAM OF THE RIGHT WRIST AND HAND:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG.

**MAXIMUS guideline:** The Expert Reviewer based his/her decision on the Non-MTUS Official Disability Guidelines (ODG), Magnetic Resonance Imaging (MRI) chapter.

**Decision rationale:** The MTUS Guidelines are silent. The ODG does not support an arthrogram to the claimant's wrist and hand. While this individual is known to be with prior diagnosis of a fifth metacarpal fracture, there is no current indication of acute clinical findings or structural abnormality that would support the need of arthrogram. In the chronic setting, MRI scans are typically recommended only for suspicion of suspected tumor, Kienbock's disease or ligamentous or tissue injury. Without clinical finding indicative of need for imaging, the acute role of an MR arthrogram would not be supported. As such, the request is not medically necessary.