

<b>Case Number:</b>	CM13-0059607		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	08/19/2012
<b>Decision Date:</b>	04/07/2014	<b>UR Denial Date:</b>	11/25/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/02/2013

### 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 Orthopedic Surgery and is licensed to practice in Texas. 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:

According to the documentation, the patient is a 61-year-old female who reported an injury on 08/19/2013. According to the documentation dated 09/06/2013, the patient had a previous history of bilateral carpal tunnel syndrome and is status post surgery for both hands, which was performed approximately one (1) decade prior to the exam. The patient reportedly had physical therapy and had improved to the point where she was able to work without any restrictions. However, in 08/2013, the patient noticed a bump on her right wrist and began having severe right thumb pain. The patient was most recently seen on 10/03/2013 with complaints of dull to sharp pain in the right wrist, occurring constantly with numbness and tingling in her 1st through 5th fingertips. The patient also has noted swelling in her right wrist, with weakness in the right hand causing her to drop objects. On the physical examination, the patient had normal muscle testing at 5/5, with reflexes +1 at the triceps, biceps, and brachioradialis, with no sensory loss to sharp or dull sensation. There was also a well-healed scar at the thenar crease bilaterally from carpal tunnel release performed in 02/2001 and 02/2002. Grip strength was noted as the patient having a twelve (12) on the right and twenty-seven (27) on the left, the second time it was ten (10) and twenty-eight (28), and the third time it was twenty (20) and thirty-one (31). Range of motion of the elbows noted flexion was 150 degrees with right and left, with extension -10 degrees on the right and -5 degrees on the left. There were no abnormalities for range of motion in the forearms and no tenderness was noted. The patient did have a negative Tinel's sign at the ulnar groove and resistance against dorsiflexion and volar flexion did not produce pain, with good stability noted to varus and valgus stress and no tenderness noted. The range of motion of the patient's wrists were listed as dorsiflexion on the right 35 degrees, with the left 60 degrees; volar flexion 35 degrees on the right and 65 on the left; with ulnar deviation of 30 degrees on the right and 35 on the left; and radial deviation 15 degrees bilaterally.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **MR ARTHROGRAM OF RIGHT WRIST:** Overturned

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

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

**Decision rationale:** The MTUS/ACOEM Guidelines indicate that the use of arthrography prior to history and physical examination by a qualified specialist is optional. It further states that use of MRI scans prior to history and physical examination by a qualified specialist is optional as well. In the case of this patient, due to the positive Tinel's sign and Finkelstein's test on the right, as well as tenderness noted on the right side of the 1st carpometacarpal wrist and volar wrist, a magnetic resonance (MR) arthrogram would be considered medically appropriate in helping to diagnosis the patient's source of pain and neurological deficits. As such, the requested MR-Arthrogram of right wrist is certified.

### **ADDITIONAL PHYSICAL THERAPY 3 X WEEK FOR 4 WEEKS FOR THE RIGHT WRIST:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG: Integrated Treatment/Disability Duration Guidelines: Physical Medicine Carpal Tunnel Syndrome (Acute & Chronic).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

**Decision rationale:** The Chronic Pain Guidelines indicate that active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. In the case of this patient, the documentation indicates that she has undergone previous physical therapy for her right wrist. The Guidelines recommend nine to ten (9 to 10) visits of physical therapy over eight (8) weeks for myalgia and myositis unspecified and eight to ten (8 to 10) visits over four (4) weeks for neuralgia, neuritis, and radiculitis unspecified. The physician has requested an excessive number of physical therapy sessions, which exceeds the maximum allowance per physical therapy guidelines. Although the patient may benefit from additional physical therapy, twelve (12) sessions is well beyond the maximum allowance under California MTUS Guidelines. Therefore, the requested service cannot be supported at this time and is non-certified.

### **ULTRAM 50MG #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96.

**Decision rationale:** The Chronic Pain Guidelines indicate that a recent review has found that this medication decreased pain intensity, produced symptom relief, and improved function for a period of time of up to three (3) months, but the benefits were small, which noted only a 12% decrease in pain intensity from the baseline. Furthermore, there are no long-term studies to allow for recommendations for longer than three (3) months. In the case of this patient, the most recent documentation does not even indicate the patient had continued to use this medication. The only medication listed is Synthroid. Without having any quantitative/objective measurements pertaining to the level of pain the patient has been experiencing as well as the efficacy of this medication, the request for continuation of its use cannot be determined. Previously, the medication had been modified for thirty (30) tablets, as there had been no documentation of a maintained increase in function or a decrease in pain with the use of Ultram. Therefore, the request cannot be supported without having documented use and efficacy of this medication towards treating the patient's pain. As such, the requested Ultram 50mg #60 is non-certified.

**CYCLOBENZAPRINE 7.5 MG #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 41-64.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril®), Page(s): 41-42.

**Decision rationale:** The Chronic Pain Guidelines indicate that cyclobenzaprine is recommended as an option, using a short course of therapy. The effect is usually greatest in the first four (4) days of treatment, suggesting that shorter courses may be better and treatment should be brief. In the case of this patient, the documentation does not provide any information pertaining to the use of this medication and how it has decreased the patient's pain or increased her functional ability. The medication had previously been reduced to thirty (30) tablets of cyclobenzaprine 7.5 mg, as a means of a possible weaning process. Without having any documentation providing quantitative/objective measurements pertaining to the efficacy of this medication, the continuation of its use cannot be supported. As such, the requested Cyclobenzaprine 7.5mg #60 is non-certified.

**NAPROXEN 550 MG #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines  
NAPROXEN Page(s): 66-69.

**Decision rationale:** The Chronic Pain Guidelines indicate that naproxen is a non-steroidal anti-inflammatory drug (NSAID) used for the relief of the signs and symptoms of osteoarthritis. It further states that if long-term or high dose therapy is required, a full dose of naproxen 500 mg twice a day appears to be the preferred choice of NSAIDs. In the case of this patient, there was no evidence of the patient being diagnosed with osteoarthritis on the exam findings. Without current documentation indicating the medical necessity for the use of this medication, the continuation of its use cannot be determined at this time. Therefore, in regard to the Naproxen 550mg #60, the request cannot be supported and is non-certified.

**PRILOSEC 20MG #60:** Upheld

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

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

**Decision rationale:** The Chronic Pain Guidelines indicate that patients at intermediate risk for gastrointestinal (GI) events and no cardiovascular disease may benefit from the use of a proton pump inhibitor. In the case of this patient, the documentation does not provide any information indicating that the patient has any gastrointestinal events as an independent diagnosis, or as a result of utilizing oral medications. Without having sufficient information pertaining to the use of a proton pump inhibitor such as Prilosec, the requested service cannot be supported, as this medication should not be used prophylactically. As such, the requested Prilosec 20mg #60 is not considered medically necessary and is non-certified