

Case Number:	CM14-0015572		
Date Assigned:	08/27/2014	Date of Injury:	04/05/2010
Decision Date:	09/29/2014	UR Denial Date:	02/04/2014
Priority:	Standard	Application Received:	02/06/2014

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 Physical Medicine & Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice Texas and Ohio. 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 59-year-old male with a reported date of injury of 04/01/1983. The mechanism of injury was not submitted within the medical records. His diagnoses were noted to include cervical myelopathy, degenerative disc disease of the cervical spine with radiculopathy, status post ACDF from C5-6, thoracolumbar myofascial complaints, medication-induced gastritis/reflux, and multilevel herniated nucleus pulposus of the lumbar spine, multilevel canal stenosis, multilevel facet arthrosis of the lumbar spine, multilevel herniated nucleus pulposus of the cervical spine, bilateral facet arthrosis at C2-3 to the C7-T1 levels, cervical canal stenosis at the C3-4 and C4-5, and cord edema or myelomalacia are present just distal to the level of the C5-6 disc. His previous treatments were noted to include massage therapy, psychiatric care, epidural steroid injection, a home exercise program, and physical therapy. The progress note dated 01/03/2014 revealed complaints of bilateral shoulders, bilateral elbows, and bilateral wrists and hands pain. The injured worker reported the pain in his hands is the most severe. The pain was exacerbated by grasping objects or when his thumb was extended. His pain was primarily located at the base of his thumb, and he complained of tingling and numbness to the hands bilaterally. The injured worker reported occasional mottling, swelling, and redness of the thenar eminence bilaterally. The injured worker continued to have discomfort in the shoulders and elbows, but the wrist and hand pain was more severe. The objective findings to the right shoulder noted decreased range of motion with full strength rated 5/5. The sensation was intact to light touch in the C5 distribution and there was mild discomfort to palpation over the acromioclavicular joint and mild pain in the acromioclavicular joint with cross arm testing. There were mild subacromial bursitis symptoms and no sign of infection. The physical examination of the left shoulder revealed decreased range of motion with 5/5 strength in all directions. The sensation was intact to light touch in a C5 distribution and there was mild

discomfort to palpation over the acromioclavicular joint and mild pain in the acromioclavicular joint with cross arm testing. The examination of the right elbow noted to have decreased range of motion with no valgus instability. There was no Tinel's over the cubital tunnel or specific tenderness about the right elbow. Motor strength was rated 5/5. The physical examination of the left elbow revealed decreased range of motion with no valgus instability. There was a negative Tinel's over the cubital tunnel and no specific tenderness about the left elbow. Motor strength was rated 5/5. The right wrist and hand examination revealed discomfort to palpation over the extensor tendons of the right wrist but no sign of infection or complex regional pain syndrome. There were negative Finkelstein's, CMC grind test, Phalen's, Tinel's, and carpal tunnel compression tests. There was no triggering of any of the fingers or thumb and the 3 consecutive grip strength readings were 45 kilograms. The range of motion was decreased and sensation was intact in all distributions. The physical examination of the left hand and wrist revealed discomfort to palpation over the extensor tendons of the left wrist but no sign of infection or complex regional pain syndrome. There were negative Finkelstein's, CMC grind test, Phalen's, Tinel's, and carpal tunnel compression tests. There was no triggering of any fingers or thumb and the grip strength test rated 45 kilograms. There was decreased range of motion and sensation was intact in all distributions. The Request for Authorization form was not submitted within the medical records. the request was for omeprazole 20 mg quantity of 60 for medication induced gastritis; bilateral universal 8 thumb spica to decrease pain, increase functional capacity, and increase to complete activities of daily living; bilateral wrist x-rays for pain; bilateral upper extremities electromyography/nerve conduction studies to evaluate the upper extremity complaints that have not been evaluated; over the counter NSAIDs for pain; and a followup visit in 5 weeks to re-evaluate complaints.

IMR ISSUES, DECISIONS AND RATIONALES

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

Omeprazole 20 mg Quantity 60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI Symptoms and Cardiovascular risk Page(s): 68.

Decision rationale: The injured worker reported medication induced gastritis. The California MTUS Chronic Pain Medical Treatment Guidelines state physicians should determine if the patient is at risk for gastrointestinal events such as age greater than 65 years; history of peptic ulcer, gastrointestinal bleeding or perforation; concurrent use of aspirin, corticosteroids, and/or an anticoagulant; or high dose/multiple NSAIDs. There is a lack of documentation regarding efficacy with this medication and the previous request for over the counter NSAIDs is not medically necessary and therefore, the continued use of omeprazole is not appropriate. Additionally, the request failed to provide the frequency at which this medication is to be utilized. The request for Omeprazole 20 mg quantity of 60 is not medically necessary.

Universal 8 Thumb Spica Right: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): Tables 11-4, 11-7.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 265-266.

Decision rationale: The injured worker complained of bilateral wrists and hands pain. The California MTUS/ACOEM Guidelines state for De Quervain's tendinitis, if not severe, it may be treated with a wrist and thumb splint and acetaminophen, then NSAIDs, if tolerated, for 4 weeks before a corticosteroid injection is considered. Carpal tunnel syndrome may be treated for a similar period with a splint and medications before injections are considered, except in the case of severe carpal tunnel syndrome. When treating with a splint in carpal tunnel syndrome, scientific evidence supports the efficacy of neutral wrist splints. Splinting should be used at night, and may be used during the day depending on activity. The guidelines recommend splinting for De Quervain's tendinitis if not severe and carpal tunnel syndrome. However, there is a lack of clinical findings consistent with De Quervain's or carpal tunnel syndrome to warrant a splint. The request for a Universal 8 Thumb Spica to the Right is not medically necessary.

Universal 8 Thumb Spica Left: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): Tables 11-4, 11-7.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 265-266.

Decision rationale: The injured worker complained of bilateral wrists and hands pain. The California MTUS/ACOEM Guidelines state for De Quervain's tendinitis, if not severe, it may be treated with a wrist and thumb splint and acetaminophen, then NSAIDs, if tolerated, for 4 weeks before a corticosteroid injection is considered. Carpal tunnel syndrome may be treated for a similar period with a splint and medications before injections are considered, except in the case of severe carpal tunnel syndrome. When treating with a splint in carpal tunnel syndrome, scientific evidence supports the efficacy of neutral wrist splints. Splinting should be used at night, and may be used during the day depending on activity. The guidelines recommend splinting for De Quervain's tendinitis if not severe and carpal tunnel syndrome. However, there is a lack of clinical findings consistent with De Quervain's or carpal tunnel syndrome to warrant a splint. The request for a Universal 8 Thumb Spica to the Left is not medically necessary.

x-ray Bilateral wrist: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Imaging.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 268-269.

Decision rationale: The injured worker complained of bilateral wrists pain. The California MTUS/ACOEM Guidelines state for most patients presenting with true hand and wrist problems, special studies are not needed until after a 4 to 6 week period of conservative care and observation. Most patients improve quickly, provided red flag conditions are ruled out. The guidelines state radiography can be used to identify and define carpal tunnel syndrome, ganglion cysts, or infection. There is a lack of clinical findings consistent with red flags to warrant an x-ray. There is no mention of any recent trauma or injury or aggravation of a pre-existing injury. There is a lack of documentation regarding conservative measures with the bilateral wrists. The request for an X-Ray to the Bilateral Wrists is not medically necessary.

EMG BUE: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): Page 261.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 268-269.

Decision rationale: The injured worker complained of numbness and tingling in the hands but no specific dermatomal or peripheral nerve distribution was noted. A previous electromyography of the bilateral upper extremities was performed on 06/11/2012 and was normal. The California MTUS/ACOEM Guidelines state that electromyography/nerve conduction velocity studies can be used to identify and define carpal tunnel syndrome. In the absence of any new objective progressive neurological deficits, a repeat electromyography/nerve conduction study is not supported by the guidelines. The request for an Electromyography to the Bilateral Upper Extremities is not medically necessary.

Nerve Conduction Study BUE: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): Page 261.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 268-269.

Decision rationale: The injured worker complained of numbness and tingling in the hands but no specific dermatomal or peripheral nerve distribution was noted. A previous nerve conduction study of the bilateral upper extremities was performed on 06/11/2012 and was normal. The California MTUS/ACOEM Guidelines state that electromyography/nerve conduction velocity studies can be used to identify and define carpal tunnel syndrome. In the absence of any new objective progressive neurological deficits, a repeat electromyography/nerve conduction study is not supported by the guidelines. The request for a Nerve Conduction Study to the Bilateral Upper Extremities is not medically necessary.

Continued OTC NSAIDS: 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 NSAIDs Page(s): 67.

Decision rationale: The injured worker has been utilizing this medication since at least 10/2013. The California MTUS Chronic Pain Medical Treatment Guidelines indicate NSAIDs are recommended for short term symptomatic relief of low back pain. It is generally recommended that the lowest effective dose be used for all NSAIDs for the shortest duration of time consistent with the individual patient treatment goals. There should be documentation of objective functional improvement and an objective decrease in pain. The guidelines recommend short term utilization of this medication and the injured worker has been on this medication for over 6 months. There is a lack of documentation regarding efficacy of this medication and improved functional status. Additionally, the request failed to provide the frequency at which this medication is to be utilized. The request for continued over the counter NSAIDs is not medically necessary.

Follow Up visit 5 weeks: 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): 268.

Decision rationale: The injured worker complained of pain to the neck, shoulder, bilateral elbows, wrists, and hands. The California MTUS/ACOEM Guidelines state patients with potentially work related forearm, wrist, and hand complaints should have followup every 3 to 5 days by a mid level practitioner, or by a physical or hand therapist who can counsel them about avoiding static positions, medication use, activity modification, and other concerns. Take care to answer questions and make sure these sessions are interactive so that the patient is duly involved in his or her recovery. If the patient has returned to work, these interactions may be done on site or by telephone, to avoid interfering with modified or full work activities. Physician followup can occur when the patient needs a release to modified, increase, or full duty, or after appreciable healing or recovery can be expected, on average. Physician followup might be expected every 4 to 7 days if the patient is off work and 7 to 14 days if the patient is working. There is a lack of documentation regarding medications being prescribed to be monitored by a physician to warrant a followup visit. There is a lack of documentation regarding a significant flare up of the injured worker's pain over the baseline to warrant a followup. The request for a Follow-Up Visit in 5 weeks is not medically necessary.