

Case Number:	CM14-0129953		
Date Assigned:	08/20/2014	Date of Injury:	04/26/2011
Decision Date:	10/01/2014	UR Denial Date:	07/17/2014
Priority:	Standard	Application Received:	08/14/2014

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 Emergency Medicine, has a Fellowship Trained in Emergency Medical Services 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 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 50-year-old female who reported an injury on 04/26/2011 due to cumulative trauma to the right wrist, elbow, and palm. Diagnoses were status post Ulnar nerve transposition, right elbow; status post-op right carpal tunnel release; status post-op de Quervain's release, right wrist; probable Ulnar nerve palsy on the left; de Quervain's on the left; and tendonitis, left wrist. Past treatment has been physical therapy. Diagnostic studies were not reported. Past surgeries were right elbow Ulnar decompression, right carpal tunnel release, and right wrist de Quervain's release. Physical examination on 05/15/2014 revealed complaints of right wrist and hand burning, pain at the palm region, with intermittent radiating pain that would shoot up the right forearm into the elbow and shoulder region. There was swelling on the inside of the right elbow. There also were complaints of left wrist and hand pain with intermittent radiating pain up the left forearm, into the elbow and shoulder region. Examination of the right upper extremity revealed right elbow had tenderness medially. Tinel's sign was negative. There was full range of motion of the right elbow. There was pain reported over the first dorsal compartment with a healed scar. There was a positive Finkelstein's test. There was tenderness over the carpal tunnel area on the right, with a negative Tinel's and negative Phalen's test. Sensation was intact in the right upper extremity. Examination of the left upper extremity revealed tenderness over the medial aspect of the left elbow, with a positive Tinel's sign. The wrist revealed full range of motion. There was tenderness over the first dorsal compartment with a positive Finkelstein's test. There was decreased sensation over the left small finger, ring finger, and long finger. There was full range of motion for bilateral shoulders, elbows, wrist, and hands. The injured worker was not on any medications. Treatment plan was for trigger point injection to the first dorsal compartment. EMG was to be requested. Medications were prescribed for

Tramadol, Naprosyn, and Prilosec. The rationale was not submitted. The Request for Authorization was submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Electromyography (EMG) bilateral upper extremities: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. 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): 268-269.

Decision rationale: The request for electromyography (EMG) bilateral upper extremities is certified. ACOEM states that the electromyography (EMG), including H-reflex tests may be useful to identify subtle, focal neurological dysfunction in patients with low back symptoms lasting more than 3 or 4 weeks. There should be documentation of 3 to 4 weeks of conservative care and observation. The right upper extremity revealed a negative Tinel's sign and negative Phalen's sign. Sensation was reported to be intact. Examination to the left upper extremity revealed tenderness over the medial aspect of the left elbow, and a positive Tinel's sign. There was a positive Finkelstein's test also. It was reported decreased sensation over the left small finger, ring finger, and long finger with approximately 7 mm 2-point discrimination. The injured worker does show focal neurologic dysfunction. Therefore, the request is certified.

Nerve conduction velocity (NCV) bilateral upper extremities: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. 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): 268-269.

Decision rationale: The request for nerve conduction velocity (NCV) bilateral upper extremities is certified. The California ACOEM states 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 improved quickly, provided red flag conditions are ruled out. In cases of peripheral nerve impingement, if no improvement or worsening has occurred within 4 to 6 weeks, electrical studies may be indicated. The primary treating physician may refer for a local Lidocaine injection with or without corticosteroids. The injured worker did reveal some neurological deficits on the physical examination. Therefore, the request is certified.

Trigger point injection to fires dorsal compartment: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. 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): 265-266.

Decision rationale: The request for trigger point injection to first dorsal web space compartment is non-certified. The California ACOEM state most invasive techniques, such as needle acupuncture and injection procedures, have insufficient high-quality evidence to support their use. The exception is corticosteroid injection into the tendon sheaths, or possibly, the carpal tunnel in cases resistant to conservative therapy for 8 to 12 weeks. For optimal care, a clinician may always try conservative methods before considering an injection. De Quervain's tendonitis, if not severe, 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 injection is considered, except in the case of severe carpal tunnel syndrome (thenar muscle atrophy and constant paresthesias in the median innervated digits). 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 carpal tunnel syndrome is made by history, physical examination, and possibly electrodiagnostic studies. Symptomatic relief from a cortisone/anesthetic injection will facilitate the diagnosis; however, the benefit from these injections is short-lived. The guidelines state that carpal tunnel should be diagnosed by physical examination, or electrodiagnostic studies. Also, it states there should be conservative therapy for 8 to 12 weeks prior to the injections. Therefore, the request is non-certified.

Retrospective for 05/15/2014 Tramadol 50mg #90 one every 6-8 hours as needed: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol (Ultram).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol, Ongoing Management, Page(s): 82, 93, 94, 113, 78.

Decision rationale: The request for retrospective for 05/15/2014 Tramadol 50 mg, quantity 90, 1 every 6 to 8 hours as needed, is non-certified. The California Medical Treatment Utilization Schedule states central analgesics drugs such as Tramadol (Ultram) are reported to be effective in managing neuropathic pain, and it is not recommended as a first-line oral analgesic. The medical guidelines recommend that there should be documentation of the 4 A's for ongoing monitoring, including analgesia, activities of daily living, adverse side effects, and aberrant drug taking behavior. The injured worker was not taking any medications at the time of this examination dated 05/15/2014. The medical guidelines state it is not recommended as a first-line oral analgesic. Therefore, the request is non-certified.

Prilosec 20mg #60 two BID: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk.

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

Decision rationale: The request for Prilosec 20 mg quantity 60 two BID is non-certified. Clinicians should determine if the patient is at risk for gastrointestinal events which include age > 65 years, a history of peptic ulcer, GI bleeding or perforation, concurrent use of ASA, corticosteroids, and/or an anticoagulant; or using a high dose/multiple NSAIDs. Patients with no risk factor and no cardiovascular disease: Non-selective NSAIDs OK (e.g., ibuprofen, naproxen, etc.) Patients at intermediate risk for gastrointestinal events and no cardiovascular disease: (1) A non-selective NSAID with either a PPI (Proton Pump Inhibitor, for example, 20 mg Omeprazole daily) or Misoprostol (200 g four times daily) or (2) a Cox-2 selective agent. Long-term PPI use (> 1 year) has been shown to increase the risk of hip fracture. Patients at high risk for gastrointestinal events with no cardiovascular disease: A Cox-2 selective agent plus a PPI if absolutely necessary. Treatment of dyspepsia secondary to NSAID therapy: Stop the NSAID, switch to a different NSAID, or consider H2-receptor antagonists or a PPI. The injured worker did not report any GI events. There was no diagnosis reported to support the use of this medication. Therefore, the request is non-certified.