

<b>Case Number:</b>	CM14-0144034		
<b>Date Assigned:</b>	10/14/2014	<b>Date of Injury:</b>	05/28/2011
<b>Decision Date:</b>	12/03/2014	<b>UR Denial Date:</b>	08/05/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/05/2014

### 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 Internal Medicine and is licensed to practice in New York. 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 claimant is a 55 year old male who sustained an industrial injury on 05/28/2011. The mechanism of injury was not provided for review. His diagnoses include left DeQuervain's disease, right DeQuervain's disease, left lateral epicondylitis, right Dupuytren's contracture, and carpal tunnel syndrome. He is s/p right and left carpal tunnel releases. He continues to complain of bilateral wrist pain. On examination of the left wrist, range of motion is decreased and painful. Flexion is 50 degrees, extension 55 degrees, radial deviation is 15 degrees and ulnar deviation is 25 degrees. There is tenderness over the dorsal and volar wrist. Right wrist range of motion is also decreased and painful. Flexion and extension is 55 degrees, radial deviation is 15 degrees and ulnar deviation is 25 degrees. There is tenderness over the dorsal and volar wrist. In addition to surgery treatment has included a home exercise program and medications: Flexeril, Ibuprofen, Norco, Ibuprofen, and Tramadol. The treating provider has requested Norco, Flexeril, Ibuprofen, Prilosec, Tramadol, bilateral tennis elbow braces, R thumb SPICA, paraffin wax, urine toxicology, and ROM.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Norco:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines California MTUS Guidelines 2009 Page(s): 91-97.

**Decision rationale:** The documentation indicates the enrollee has been treated with opioid therapy with Norco for pain control. Per California MTUS Guidelines, short-acting opioids such as Norco are seen as an effective method in controlling chronic pain. They are often used for intermittent or breakthrough pain. The treatment of chronic pain with any opioid agent requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include current pain: last reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid, and the duration of pain relief. Per the medical documentation there has been no documentation of the medication's pain relief effectiveness and no clear documentation that he has responded to ongoing opioid therapy. According to the California MTUS Guidelines there has to be certain criteria followed including an ongoing review and documentation of pain relief and functional status. This does not appear to have occurred with this patient. The patient has continued pain despite the use of short acting opioid medications. Medical necessity for Norco 10/325 has not been established. The requested treatment is not medically necessary.

**Flexeril:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines California MTUS 2009 Page(s): 64.

**Decision rationale:** Per the reviewed literature, Flexeril (Cyclobenzaprine) is not recommended for long-term treatment of wrist pain. The medication has its greatest effect in the first four days of treatment. The documentation indicates there are no palpable muscle spasms and there is no documentation of functional improvement from any previous use of this medication. Per CA MTUS Guidelines muscle relaxants are not considered any more effective than non-steroidal anti-inflammatory medications alone. Based on the currently available information, the medical necessity for this muscle relaxant medication has not been established. The requested treatment is not medically necessary.

**Ibuprofen 800mg:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines California MTUS Guidelines 2009 Page(s): 67.

**Decision rationale:** The requested medication, Ibuprofen is medically necessary for the treatment of the claimant's pain condition. Ibuprofen is a non-steroidal anti-inflammatory medication (NSAID). These medications are recommended for the treatment of chronic pain as a

second line therapy after acetaminophen. The documentation indicates the claimant has significant bilateral wrist and left elbow pain and the medication has proved beneficial in conjunction with other treatment modalities. Medical necessity for the requested item has been established. The requested treatment is medically necessary.

**Prilosec:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines California MTUS 2009 Page(s): 68.

**Decision rationale:** Per California MTUS 2009 proton pump inhibitors are recommended for patients taking NSAIDs with documented GI distress symptoms or specific GI risk factors. There is no documentation indicating the patient has any symptoms or GI risk factors. GI risk factors include: age >65, history of peptic ulcer, GI bleeding, or perforation; concurrent use of aspirin, corticosteroids, and/or anticoagulants or high dose/multiple NSAID. Based on the available information provided for review, the medical necessity for Prilosec has not been established. The requested medication is not medically necessary.

**Tramadol:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines California MTUS 2009 Page(s): 93, 94-96.

**Decision rationale:** The review of the medical documentation indicates that the requested medication, Ultram is not medically necessary and indicated for the treatment of the claimant's chronic pain condition. Per California MTUS, Ultram (Tramadol) is a synthetic opioid which affects the central nervous system and is indicated for the treatment of moderate to severe pain. The treatment of chronic pain with any opioid agent requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include current pain: last reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid, and the duration of pain relief. Per the medical documentation there has been no documentation of the medication's pain relief effectiveness and no clear documentation that he has responded to ongoing opioid therapy. According to the California MTUS Guidelines there has to be certain criteria followed including an ongoing review and documentation of pain relief and functional status. This does not appear to have occurred with this patient. The patient may require a multidisciplinary evaluation to determine the best approach to treatment of her chronic pain syndrome. Medical necessity for the requested item has not been established. The requested treatment is not medically necessary.

**Bilateral tennis elbow brace:** 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:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Elbow problems

**Decision rationale:** There is no documentation provided necessitating a right thumb SPICA splint. Per the reviewed guidelines splinting of the wrist in a neutral position is recommended an night and day as needed, as an option in conservative treatment. Use of daytime splinting has positive, but limited evidence. Splinting after surgery has negative evidence. Medical necessity for the requested treatment has not been established. The requested treatment is not medically necessary.

**Right thumb SPICA:** 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 Chronic Pain Treatment Guidelines Official Disability Guidelines (ODG) Wrist problems.

**Decision rationale:** There is no documentation provided necessitating a right thumb SPICA splint. Per the reviewed guidelines splinting of the wrist in a neutral position is recommended an night and day prn, as an option in conservative treatment. Use of daytime splinting has positive, but limited evidence. Splinting after surgery has negative evidence. Medical necessity for the requested treatment has not been established. The requested treatment is not medically necessary.

**Paraffin wax:** 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:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hand treatments

**Decision rationale:** Per the reviewed guidelines paraffin wax baths are recommended as an option for arthritic hands if used as an adjunct to a program of evidence -based conservative care. There is no indication the claimant has arthritis. The paraffin wax treatments are being requested for the treatment of edema. There is limited evidence that this type of modality can address the issues with edema. Medical necessity for the requested item has not been established. The requested item is not medically necessary.

**Urine toxicology screening:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Procedure Summary

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines California MTUS Guidelines 2009 Drug testing Page(s): 43.

**Decision rationale:** The patient's provider requested a urine drug screen. The patient is maintained on a medical regimen which includes non-steroidal anti-inflammatory medications, muscle relaxants, Norco, and Tramadol. Per Chronic Pain Management Treatment Guidelines, screening is recommended in chronic pain patients to differentiate dependence and addiction with opioids as well as compliance and potential misuse of other medications. The test is being requested to incorporate the results into the patient's treatment plan and continue his present medication regimen. Medical necessity for the requested item has been established. The requested item is medically necessary.

**ROM:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Medscape Internal Medicine 2103: Range of Motion Testing

**Decision rationale:** To measure range of motion, physical therapists most commonly use a goniometer, which is an instrument used to measure angle at a joint. Goniometers show degrees of an angle from zero to 180 or 360 degrees and are available in different shapes and sizes for the unique joints in the human body. There is no specific indication for the requested electronic device requested. Medical necessity for the requested item has not been established. The requested item is not medically necessary.