

<b>Case Number:</b>	CM14-0026508		
<b>Date Assigned:</b>	07/02/2014	<b>Date of Injury:</b>	11/07/2013
<b>Decision Date:</b>	08/11/2014	<b>UR Denial Date:</b>	02/25/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/03/2014

### 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 and Rehabilitation 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 62-year-old female who reported an injury on 11/07/2013. The mechanism of injury was noted to be a trip and fall. The injured worker had prior treatments of medications, therapy, and surgery. The injured worker's diagnoses were noted to be left distal radius fracture malunion with ulnar styloid fracture. A postoperative examination dated 12/16/2013 noted that the injured worker continued with postoperative discomfort. She denied any numbness or tingling. She had been working on finger and upper arm range of motion and reported that the thumb was especially stiff and sore with motion. The objective findings included removing the dressings. The surgical incision were well approximated. The injured worker had moderate swelling, as expected, given the severity of injury and the point of postoperative. The sutures were removed without incident. Her sensory was intact distally. Her finger range of motion was 60% of normal, with reports of wrist level pain. The injured worker received a new long arm cast and was encouraged to continue with finger as well as thumb motion. The injured worker was provided a followup appointment. The provider's rationale for the request was not provided within the documentation. A Request for Authorization for medical treatment was not provided within the documentation.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Occupational therapy left wrist three times a week for four weeks (quantity 12 sessions):**  
Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine 98-99.

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): page(s) 20.

**Decision rationale:** The request for occupational therapy to the left wrist 3 times per week times 4 weeks (quantity of 12 sessions) is not medically necessary. The California MTUS Postsurgical Treatment Guidelines indicate postsurgical treatments of 16 visits over 8 weeks, with a postsurgical physical medicine treatment period of 4 months. The documentation provided noted that the injured worker participated in occupational therapy. It was not noted how many occupational therapy visits had been completed at this time. The documentation provided for review failed to provide an adequate assessment of the injured worker's range of motion and motor strength. The documentation does not indicate significant functional limitations. In addition, the post surgical treatment period is longer than 4 months. Therefore, the request for occupational therapy to the left wrist 3 times per week times 4 weeks (quantity of 12 sessions) is not medically necessary.

**Anaprox-DS Sodium 550mg #180:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAID's Page(s): 67-68.

**Decision rationale:** The request for Anaprox DS sodium 550 mg quantity of 180 is not medically necessary. The California MTUS Chronic Pain Medical Treatment Guidelines provide specific recommendations for osteoarthritis and use of NSAIDs. The guidelines recommend the lowest dose for the shortest period of time in injured workers with moderate to severe pain. The guidelines indicate NSAIDs appear to be superior to acetaminophen, particularly for injured workers with moderate to severe pain. There was no evidence to recommend 1 drug in this class over another based on efficacy. The injured worker has documented pain. However, the indication of the severity of pain is not well documented. It was also not documented if Anaprox has provided any efficacy in the postoperative report dated 12/16/2013. The documentation failed to indicate a length of Anaprox therapy. The dose requested is the maximum dose recommended by the guidelines. In addition, the request failed to indicate a frequency. Therefore, the request for Anaprox DS sodium 550 mg quantity of 180 is not medically necessary.

**Prilosec delayed 20mg #180:** Upheld

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

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

**Decision rationale:** The request for Prilosec delayed 20 mg quantity of 180 is not medically necessary. The California MTUS Chronic Pain Medical Treatment Guidelines indicate a recommendation for proton pump inhibitors with the use of NSAIDs. The injured worker's clinical documentation does not provide any indication of gastrointestinal events. The documentation fails to provide any efficacy with the use of Prilosec. The request fails to indicate a frequency. Therefore, the request for Prilosec delayed 20 mg quantity of 180 is not medically necessary.

**Ultracet tab 325 mg #120:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol Page(s): 94-95.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): page(s) 84.

**Decision rationale:** The request for ultracet tab 325 mg quantity of 120 is not medically necessary. The California MTUS Chronic Pain Medical Treatment Guidelines do not recommend opioids as a first line therapy. This specific opioid has been found to decrease pain intensity; it does produce symptom relief; and it improves function for a time period of up to 3 months, but the benefits are small. There are no long-term studies to allow for recommendations for longer than 3 months of ultracet. It is not noted what duration of ultracet therapy was recommended. The efficacy was also not documented within the review. The request failed to provide a frequency. Therefore, the request for ultracet tab 325 mg quantity of 120 is not medically necessary.