

<b>Case Number:</b>	CM14-0067457		
<b>Date Assigned:</b>	07/11/2014	<b>Date of Injury:</b>	10/21/2010
<b>Decision Date:</b>	08/21/2014	<b>UR Denial Date:</b>	05/12/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/12/2014

### 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 Occupational Medicine 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 patient is a 49 year old female who was injured on 10/21/10. The mechanism of injury is unknown. She has been treated with 16 visits of physical therapy. Physical therapy note dated 05/02/2014 states the patient presented to visit with flare up of symptoms and only reporting 25% improvement. She still has sharp pain in palmar hands with cramping and holding. On exam, range of motion of the right wrist revealed extension to 50 degrees and flexion to 24 degrees and motor strength is 5/5. The left wrist revealed flexion to 60 degrees and extension to 60 degrees. Her grip strength on the right revealed 45, 35, 32 and on the left revealed 35, 32, 30. On physical therapy note dated 02/20/2014, which is session #8, the patient complained of sharp pain in the palmar of hands that is frequent. She continued to have difficulty gripping objects. Her exam revealed range of motion of the right wrist to 25% with +4/5 strength. Her strength is noted to have increased and she demonstrated progress in activity tolerance but continued to have functional limitations. She has a diagnosis of wrist tendinitis and cervical sprain/strain. No other information regarding medications or cervical spine sprain is presented for review. Prior utilization review dated 05/12/2014 states the request for Continue Physical Therapy Two (2) Times A Week For Six (6) Weeks is not certified, Tramadol 50mg #60 is not certified, and Flexeril 10mg #30 is not certified as medical necessity has not established due to lack of documented evidence.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Tramadol 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:** According to MTUS guidelines, opioids are recommended for moderate to severe pain. Efficacy of long-term use is not clearly established. In this case a request is made for Tramadol. However, history and examination findings do not support its use. Clinically significant functional improvement from use of Tramadol is not documented. Medical necessity is not established.

**Flexeril 10mg, #30:** 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 Muscle Relaxants Page(s): 63-6.

**Decision rationale:** According to MTUS guidelines, muscle relaxants are indicated for short-term treatment of acute exacerbations of chronic low back pain. Long-term use is not recommended. In this case a request is made for Flexeril. However, history and examination findings do not support its use. Efficacy, indication, and duration of use are not provided. Medical necessity is not established.

**Continue Physical Therapy Two (2) Times a Week for Six (6) Weeks:** 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 Physical Medicine Page(s): 98-9.

**Decision rationale:** According to MTUS guidelines, physical medicine (physical therapy) is recommended for chronic musculoskeletal pain up to 10 visits over 8 weeks with additional therapy dependent upon demonstrated functional improvement. In this case a request is made for 12 additional physical therapy visits. However, the patient appears to have already completed 18 visits. Clinically significant functional improvement is not clearly demonstrated from the provided records. Medical necessity is not established.