

Case Number:	CM14-0150738		
Date Assigned:	10/23/2014	Date of Injury:	05/17/2010
Decision Date:	01/27/2015	UR Denial Date:	08/18/2014
Priority:	Standard	Application Received:	09/16/2014

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 Orthopedic Surgery 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:

According to the records made available for review, this is a 39-year-old female with a 5/17/10 date of injury, and status post open reduction and internal fixation left distal radius ulnar fracture 5/17/10, status post left cubital tunnel release/ulnar nerve anterior subcutaneous decompression and transposition 1/12/11, status post removal of left distal radius plate and screws, release of left 1st dorsal compartment, scar revision, release of 2nd dorsal compartment intersection region and removal of foreign body 11/7/11, status post irrigation and debridement, tenolysis, and wound closure left dorsal compartment 12/20/11, and status post left hand scar revision, total wrist arthrodesis, tenosynovectomy 4th and 5th dorsal compartment extensor tendons and removal of bone graft, left distal radius 1/30/13. At the time (8/18/14) of request for authorization for associated surgical service: post op application of custom short arm splint, associated surgical service: Post op occupational therapy three times a week for four weeks with CHT, one day after surgery, associated surgical service: post op cold therapy unit, 30 day rental, associated surgical service: post op CPM device for finger movement, associated surgical service: Norco (Hydrocodone/APAP) 10/325mg #90 with one refill, Q4-6h prn, Zofran (Ondansetron ODT) 4mg #30 with one refill, QD, cyclobenzaprine (Fexmid) 7.5mg #90 with one refill, TID prn, hydrocodone/Acetaminophen (Norco) 10/325mg #90 with one refill, Q4-6H prn, and omeprazole DR (Prilosec) 20mg #30 with one refill, QD prn, there is documentation of subjective (pain in the left elbow that radiates to hand and fingers, tightness of the left elbow that radiates to the forearm/hand, weakness of the left hand, dropping objects with the left hand, tingling sensation in the left thumb, index, long, ring and little fingers, and swelling of the left hand) and objective (positive Flick test, decreased light touch and 2 point discrimination, mild thenar atrophy) findings, current diagnoses (left carpal tunnel syndrome, status post left wrist fusion, and chronic left dorsal hand/wrist/forearm fusion plate pain), and treatment to date (physical therapy,

splinting, injection and medications). Medical records identify a certification for median nerve carpal tunnel, wrist flexor tenosynovectomy, advancement tissue rearrangement of hand, synovectomy extensor tendon single compartment, and removal of deep implant. Regarding the requested associated surgical service: post op CPM device for finger movement, there is no documentation of a pending flexor tendon repair. Regarding the requested cyclobenzaprine (Fexmid) 7.5mg #90 with one refill, TID prn, there is no documentation that cyclobenzaprine is being used as a second line option and an intention for short-term (less than two weeks) treatment. Regarding the requested omeprazole DR (Prilosec) 20mg #30 with one refill, QD prn, there is no documentation of risk for gastrointestinal event.

IMR ISSUES, DECISIONS AND RATIONALES

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

Associated surgical service: Post op application of custom short arm splint: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 270, Acupuncture Treatment Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Carpal Tunnel Syndrome, Splinting.

Decision rationale: MTUS reference to ACOEM guidelines identifies that two prospective randomized studies show no benefit effect from postoperative splinting after carpal tunnel release when compared to bulky dressing alone. ODG identifies that splinting after surgery has negative evidence. Therefore, based on guidelines and a review of the evidence, the request for associated surgical service: post op application of custom short arm splint is not medically necessary.

Associated surgical service: Post op occupational therapy three times a week for four weeks with CHT, one day after surgery: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Â§ 9792.24. 3. Postsurgical Treatment Guidelines; and Title 8, California Code of Regulations, section 9792.20.

Decision rationale: MTUS Postsurgical Treatment Guidelines identifies up to 3-8 visits of post-operative physical therapy over 3-5 weeks and post-surgical physical medicine treatment period of up to 3 months. In addition, MTUS Postsurgical Treatment Guidelines identifies that the initial course of physical therapy following surgery is 1/2 the number of sessions recommended for the general course of therapy for the specified surgery. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or

improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of left carpal tunnel syndrome, status post left wrist fusion, and chronic left dorsal hand/wrist/forearm fusion plate pain. In addition, there is documentation a pending surgery that is medically necessary. However, given that the request is for post op occupational therapy three times a week for four weeks, the proposed number of visits exceeds guidelines. Therefore, based on guidelines and a review of the evidence, the request for associated surgical service: Post op occupational therapy three times a week for four weeks with CHT, one day after surgery is not medically necessary.

Associated surgical service: Post op cold therapy unit, 30 day rental: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Cervical, Shoulder, Knee, and Lumbar Chapters

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 265. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: PMID: 18214217 PubMed - indexed for MEDLINE.

Decision rationale: MTUS reference to ACOEM identifies patients' at-home applications of heat or cold packs may be used before or after exercises and are as effective as those performed by a therapist. Medical Treatment Guideline identifies generally, solely an analgesic effect was demonstrated by the use of continuous cooling; that crushed ice, cold packs and electric-powered cooling devices differ in handling, effect and efficiency; and that the exact recommendations on application time and temperature cannot be given. Therefore, based on guidelines and a review of the evidence, the request for associated surgical service: Post op cold therapy unit, 30 day rental is not medically necessary.

Associated surgical service: Post op CPM device for finger movement: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm/Wrist/Hand, Continuous passive motion (CPM).

Decision rationale: MTUS does not address this issue. ODG identifies documentation of flexor tendon repair in the hand as criteria necessary to support the medical necessity of continuous passive motion (CPM). Within the medical information available for review, there is documentation of diagnoses of left carpal tunnel syndrome, status post left wrist fusion, and chronic left dorsal hand/wrist/forearm fusion plate pain. In addition, there is documentation of a pending surgery that is medically necessary. However, there is no documentation of a pending flexor tendon repair. Therefore, based on guidelines and a review of the evidence, the request for associated surgical service: post op CPM device for finger movement is not medically necessary.

Associated surgical service: Norco (Hydrocodone/APAP) 10/325mg #90 with one refill, Q4-6h prn: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 82-91.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47-48.

Decision rationale: MTUS reference to ACOEM identifies documentation of severe pain, as criteria necessary to support the medical necessity of opioid therapy for a short period of time. Within the medical information available for review, there is documentation of diagnoses of left carpal tunnel syndrome, status post left wrist fusion, and chronic left dorsal hand/wrist/forearm fusion plate pain. In addition, there is documentation of a pending surgery that is medically necessary. Therefore, based on guidelines and a review of the evidence, the request for associated surgical service: Norco (Hydrocodone/APAP) 10/325mg #90 with one refill, Q4-6h prn is medically necessary. This review presumes that a surgery is planned and will proceed. There is no medical necessity for this request if the surgery does not occur. Therefore this request is medically necessary.

Zofran (Ondansetron ODT) 4mg #30 with one refill, QD: 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), Pain Chapter, Anti-emetic

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Antiemetics (for opioid nausea).

Decision rationale: MTUS does not address the issue. ODG identifies documentation of nausea and vomiting secondary to chemotherapy and radiation treatment, postoperative use, or acute use for gastroenteritis, as criteria necessary to support the medical necessity of Ondansetron (Zofran). Within the medical information available for review, there is documentation of diagnoses of left carpal tunnel syndrome, status post left wrist fusion, and chronic left dorsal hand/wrist/forearm fusion plate pain. In addition, there is documentation of a pending surgery that is medically necessary. Therefore, based on guidelines and a review of the evidence, the request for Zofran (Ondansetron ODT) 4mg #30 with one refill, QD is medically necessary. This review presumes that a surgery is planned and will proceed. There is no medical necessity for this request if the surgery does not occur.

Cyclobenzaprine (Flexmid) 7.5mg #90 with one refill, TID prn: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for pain) Page(s): 63-64. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Muscle relaxants (for pain).

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of acute exacerbation of chronic low back pain and used as a second line option for short-term treatment, as criteria necessary to support the medical necessity of muscle relaxant. ODG identifies that muscle relaxants are recommended for short-term (less than two weeks) treatment. Within the medical information available for review, there is documentation of diagnoses of left carpal tunnel syndrome, status post left wrist fusion, and chronic left dorsal hand/wrist/forearm fusion plate pain. In addition, there is documentation of a pending surgery that is medically necessary. However, there is no documentation that cyclobenzaprine is being used as a second line option. In addition, given that the request is for cyclobenzaprine (Fexmid) 7.5mg #90 with one refill, TID prn, there is no documentation of an intention for short-term (less than two weeks) treatment. Therefore, based on guidelines and a review of the evidence, the request for cyclobenzaprine (Fexmid) 7.5mg #90 with one refill, TID prn is not medically necessary.

Hydrocodone/Acetaminophen (Norco) 10/325mg #90 with one refill, Q4-6H prn: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 82-91.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47-48.

Decision rationale: MTUS reference to ACOEM identifies documentation of severe pain, as criteria necessary to support the medical necessity of opioid therapy for a short period of time. Within the medical information available for review, there is documentation of diagnoses of left carpal tunnel syndrome, status post left wrist fusion, and chronic left dorsal hand/wrist/forearm fusion plate pain. In addition, there is documentation of a pending surgery that is medically necessary. However, given documentation of an associated surgical request for Hydrocodone/Acetaminophen (Norco) 10/325mg #90 with one refill, Q4-6H prn, this represents a duplicate request without documentation of the medical necessity to support duplicate prescriptions. Therefore, based on guidelines and a review of the evidence, the request for Hydrocodone/Acetaminophen (Norco) 10/325mg #90 with one refill, Q4-6H prn is not medically necessary.

Omeprazole DR (Prilosec) 20mg #30 with one refill, QD prn: 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 & cardiovascular risk Page(s): 68-69. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), Proton pump inhibitors (PPIs).

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies that risk for gastrointestinal event includes age > 65 years; history of peptic ulcer, GI bleeding or perforation; concurrent use of ASA, corticosteroids, and/or an anticoagulant; and/or high dose/multiple NSAID. ODG identifies documentation of risk for gastrointestinal events, preventing gastric ulcers induced by NSAIDs, as criteria necessary to support the medical necessity of omeprazole. Within the medical information available for review, there is documentation of diagnoses of left carpal tunnel syndrome, status post left wrist fusion, and chronic left dorsal hand/wrist/forearm fusion plate pain. In addition, there is documentation of a pending surgery that is medically necessary. However, there is no documentation of risk for gastrointestinal event. Therefore, based on guidelines and a review of the evidence, the request for omeprazole DR (Prilosec) 20mg #30 with one refill, QD prn is not medically necessary.