MAXIMUS Federal Services

| Case Number: | CM14-0208986 | | |
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| Date Assigned: | 02/03/2015 | Date of Injury: | 07/26/2014 |
| Decision Date: | 03/05/2015 | UR Denial Date: | 12/02/2014 |
| Priority: | Standard | Application Received: | 12/15/2014 |

## 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: California
Certification(s)/Specialty: Orthopedic Surgery, Sports Medicine

## 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 42-year-old female who reported injury on 07/28/2014. The mechanism of injury was the injured worker was stapling mail. The injured worker underwent a prior left carpal tunnel release. Other therapies included an injection. The injured worker underwent an x-ray of the left wrist, which was noted to be normal. The documentation of 11/19/2014 revealed the injured worker had left hand complaints. The injured worker was noted to have corticosteroid injections and be treated with 6 sessions of therapy, which were noted to be ineffective. The injured worker indicated her biggest complaint was her left thumb, and there was a tender lump, which made it difficult to grab, squeeze, pinch, etc. The surgical history was noted to include bilateral carpal tunnel releases and bilateral ganglion cyst excisions. The injured worker's medications were noted to include Ambien 5 mg. The injured worker had full range of motion of the wrists bilaterally. There was no radiocarpal tenderness or snuff box or scapholunate tenderness. Examination of the thumb revealed full range of motion, and there was a tender firm lump over the volar metacarpophalangeal joint, roughly 2 to 3 mm in diameter consistent with a probably retinacular cyst. There was no triggering or locking. The neurovascular examination was intact. There was an area of significant tenderness just ulnar to the mid index metacarpal between the middle and ring finger metacarpal necks. An ultrasound was performed on the date of examination. The ultrasound revealed the injured worker had 2 retinacular cysts roughly 3 mm in diameter over the volar metacarpophalangeal joint flexor tendon sheath. The flexor tendons were unremarkable. The metacarpophalangeal joint and neurovascular structures were intact. The physician injected the injured worker's thumb flexor

tendon sheath under ultrasound guidance, and the injured worker had the majority of her symptoms resolve. The diagnosis included flexor retinacular cyst left thumb and possible neuroma left hand. The treatment plan included an open excision under local anesthesia. The physician opined the injured worker may have a neuroma in her left hand. The injured worker's medical history included hypertension and cervical and breast cancer. There was a Request for Authorization submitted for review. The Request for Authorization indicated the request was made for a GameReady unit additionally.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Fluoroscopy:** 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) Low Back Chapter, Fluoroscopy, (ESI).

**Decision rationale:** The Official Disability Guidelines address fluoroscopy for epidural steroid injections. The request as submitted failed to indicate a rationale for the fluoroscopy. Additionally, the request failed to indicate the quantity or duration. As such, it would not be supported. Given the above, the request for fluoroscopy is not medically necessary.

**Twelve sessions of post-operative physical therapy:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 10, 21.

**Decision rationale:** The California Post-Surgical Treatment Guidelines indicate that the treatment for removal of a cyst of the synovium, tendon, or bursa would be supported for 18 visits, with the initial quantity of sessions being have the number of recommended sessions. The request as submitted failed to indicate the body part and laterality to be treated. If the surgical intervention was approved, and the body part to be treated was included, this request would be supported for 9 visits of postoperative therapy. Given the above, the request for 12 sessions of postoperative physical therapy is not medically necessary.

**Cold compression unit for fourteen days:** 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) Knee & Leg Chapter, Game Ready accelerated recovery system.

**Decision rationale:** The Official Disability Guidelines indicate that GameReady therapy is continuous flow cryotherapy with the use of vasocompression. There are no published high quality studies on the GameReady device or any other combined system. Additionally, the request would not be supported, as there was a lack of documentation indicating the body part to be treated with the cold compression therapy. There was a lack of documentation indicating the injured worker could not be treated with ice packs. Given the above, the request for cold compression unit for 14 days is not medically necessary.

**Norco 10/325 mg, 120 count:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 76 - 80.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic pain, ongoing management, opioid dosing. Page(s): 60,78,86.

**Decision rationale:** The California Medical Treatment Utilization Schedule Guidelines recommend opioids for the treatment of chronic pain. There should documentation of objective functional improvement and an objective decrease in pain. There should be documentation the injured worker is being monitored for aberrant drug behavior and side effects. The clinical documentation submitted for review indicated the request was made for refill of the medications for surgical pain relief. However, as this was noted to be a continuation of medication usage, there was a lack of documentation of objective functional improvement, an objective decrease in pain, and documentation the injured worker was being monitored for aberrant drug behavior and side effects. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Norco 10/325 mg 120 count is not medically necessary.

**Naproxen 550 mg, 120 count:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 66 and 73.

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

**Decision rationale:** The California Medical Treatment Utilization Schedule Guidelines indicate NSAIDs are recommended for the short term symptomatic relief of pain. The clinical documentation submitted for review indicate the injured worker would be prescribed the medication as a postoperative medication. This medication would be supported for post-operative use, if the frequency was provided. The request as submitted failed to indicate the

frequency for requested medication, and as such, this request would not be supported. Given the above, the request for Naproxen 550 mg 120 count is not medically necessary.

**Zolpidem 5 mg, thirty count:** 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), Pain (Chronic) Chapter

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Official Disability Guidelines (ODG) Pain Chapter, Zolpidem.

**Decision rationale:** The Official Disability Guidelines indicate that zolpidem is recommended for the short term treatment of insomnia, up to 10 days. The clinical documentation submitted for review indicated the injured worker had previously utilized the medication. There was a lack of documentation of exceptional factors to warrant nonadherence to guideline recommendations. There was a lack of documentation of objective functional benefit. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for zolpidem 5 mg 30 count is not medically necessary.

**Zofran 8 mg, ten count:** 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) Pain Chapter, Ondansetron.

**Decision rationale:** The Official Disability Guidelines indicate that ondansetron is recommended for postoperative nausea and vomiting. The clinical documentation submitted for review indicated the injured worker had been recommended for surgical intervention and it would have been supported, if the surgical intervention is supported and if the frequency was provided. The request as submitted, however, failed to indicate the frequency for the requested medication. Given the above, the request for Zofran 8 mg 10 count is not medically necessary.

**Colace 100 mg, twenty count:** 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 Initiation of Opioid Therapy Page(s): 77.

**Decision rationale:** The California Medical Treatment Utilization Schedule guidelines recommend medication should be started to decrease constipation upon the initiation of opioid

therapy. The clinical documentation submitted for review failed to provide a rationale for the Colace. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Colace 100 mg 20 count is not medically necessary.