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| Case Number: | CM15-0143608 | | |
| Date Assigned: | 08/04/2015 | Date of Injury: | 12/15/2010 |
| Decision Date: | 09/08/2015 | UR Denial Date: | 07/17/2015 |
| Priority: | Standard | Application Received: | 07/24/2015 |

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: Texas, California
 Certification(s)/Specialty: Family Practice

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This is a 61 year old male with a December 15, 2010 date of injury. A progress note dated July 7, 2015 documents subjective complaints (pain at the right proximal palm; no further numbness and tingling following endoscopic carpal tunnel release on May 15, 2015), objective findings (mild swelling and tenderness of the right proximal palm; surgical site well healed without infection; slight limitation and full composite flexion of all fingers of the right hand with full extension), and current diagnoses (status post endoscopic carpal tunnel release with resolution of neurogenic symptoms with continued weakness and stiffness). Treatments to date have included carpal tunnel release, medications, electrodiagnostic testing that showed bilateral mild ulnar neuropathy of the elbow and mild right carpal tunnel syndrome, and therapy. The treating physician documented a plan of care that included occupational therapy, Voltaren 100mg #60, and Protonix 20mg #30. The medication list includes Protonix and Voltaren. A recent detailed clinical examination of the gastrointestinal tract was not specified in the records provided. The patient has had EMG on 2/6/15 that revealed bilateral ulnar neuropathy and mild CTS. The patient had received 9 OT visits for this injury.

IMR ISSUES, DECISIONS AND RATIONALES

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

Occupational therapy 3 times week for 4 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

Decision rationale: Request Occupational therapy 3 times week for 4 weeks. CA MTUS Post-Surgical Rehabilitation guidelines cited below recommend 3-8 visits over 3-5 weeks and postsurgical physical medicine treatment period is 3 months. The patient had received 9 OT visits for this injury. The requested additional visits in addition to the previously certified OT sessions are more than recommended by the cited criteria. There was no evidence of ongoing significant progressive functional improvement from the previous occupational visits that is documented in the records provided. In addition as per cited guidelines Frequency of visits shall be gradually reduced or discontinued as the patient gains independence in management of symptoms and with achievement of functional goals. Patient education regarding postsurgical precautions, home exercises, and self-management of symptoms should be ongoing components of treatment starting with the first visit. Intervention should include a home exercise program to supplement therapy visits. Per the guidelines cited, Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Furthermore, documentation of response to other conservative measures such as oral pharmacotherapy like NSAIDS, in conjunction with rehabilitation efforts was not provided in the medical records submitted. A valid rationale as to why remaining rehabilitation cannot be accomplished in the context of an independent exercise program for the bilateral wrists is not specified in the records provided. The medical necessity of the request for Occupational therapy 3 times week for 4 weeks is not fully established in this patient, therefore is not medically necessary.

Voltaren 100mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67-68.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-inflammatory medications page 22. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain chapter Pain (updated 07/15/15) Diclofenac.

Decision rationale: Voltaren 100mg #60. Diclofenac belongs to a group of drugs called non-steroidal anti-inflammatory drugs (NSAIDs). According to CA MTUS, Chronic pain medical treatment guidelines, Anti-inflammatories are the traditional first line of treatment, to reduce pain so activity and functional restoration can resume, but long-term use may not be warranted. (Van Tulder-Cochrane, 2000) In addition as per cited guideline, Diclofenac is not recommended as first line due to increased risk profile. A large systematic review of available evidence on NSAIDs confirms that Diclofenac, a widely used NSAID, poses an equivalent risk of cardiovascular events to patients as did rofecoxib (Vioxx), which was taken off the market. According to the authors, this is a significant issue and doctors should avoid Diclofenac because it increases the risk by about 40%. Another meta-analysis supported the substantially increased risk of stroke with Diclofenac, further suggesting it not be a first-line NSAID it should only be

used for the shortest duration possible in the lowest effective dose due to reported serious adverse events. Post marketing surveillance has revealed that treatment with all oral and topical Diclofenac products may increase liver dysfunction, and use has resulted in liver failure and death. In 2009 the FDA issued warnings about the potential for elevation in liver function tests during treatment with all products containing Diclofenac sodium. (FDA, 2009) With the lack of data to support superiority of Diclofenac over other NSAIDs and the possible increased hepatic and cardiovascular risk associated with its use, alternative analgesics and/or non-pharmacological therapy should be considered. The AGS updated Beers criteria for inappropriate medication use includes Diclofenac. (AGS, 2012) Diclofenac is associated with a significantly increased risk of cardiovascular complications and should be removed from essential-medicines lists, according to a new review. Diclofenac is a NSAID. Short term use of a NSAID is considered first line treatment for musculoskeletal pain. However, Diclofenac is not recommended as a first-line treatment and has increased risk of cardiovascular side effects. Patient is having chronic pain and is taking Diclofenac for this injury. Response to Diclofenac in terms of functional improvement is not specified in the records provided. The need for Diclofenac on a daily basis with lack of documented improvement in function is not fully established. Any lab tests to monitor for side effects like renal dysfunction due to taking NSAIDS for a long period of time were not specified in the records provided. The medical necessity of the request for Voltaren 100mg #60 is not fully established for this patient due to its risk profile, therefore is not medically necessary.

Protonix 20mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68-69.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk, page 68-69.

Decision rationale: Protonix 20mg #30. Per the CA MTUS NSAIDs guidelines cited below, regarding use of proton pump inhibitors with NSAIDs, the MTUS Chronic Pain Guidelines recommend PPIs in, Patients at intermediate risk for gastrointestinal events; Patients at high risk for gastrointestinal events, Treatment of dyspepsia secondary to NSAID therapy. Per the cited guidelines, patient is considered at high risk for gastrointestinal events with the use of NSAIDS when (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA). There is no evidence in the records provided that the patient has GI symptoms with the use of NSAIDs. The records provided do not specify any objective evidence of GI disorders, GI bleeding or peptic ulcer. The medical necessity of the request for Protonix 20mg #30 is not fully established in this patient therefore is not medically necessary.