

Case Number:	CM15-0216746		
Date Assigned:	11/06/2015	Date of Injury:	01/17/2014
Decision Date:	12/18/2015	UR Denial Date:	11/02/2015
Priority:	Standard	Application Received:	11/03/2015

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: Maryland, Virginia, North Carolina
 Certification(s)/Specialty: Plastic Surgery

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 30 year old female sustained an industrial injury on 1-17-14. Documentation indicated that the injured worker was receiving treatment for right carpal tunnel syndrome, bilateral shoulder sprain and strain and left wrist pain. Previous treatment included physical therapy, injections and medications. In a PR-2 dated 7-6-15, the injured worker complained of ongoing numbness and tingling in the right thumb, index and middle fingers that was not relieved by an injection into the right carpal tunnel at the last office visit. The physician's impression was possible bilateral carpal tunnel syndrome despite normal electrodiagnostic testing and no response from injection at the right carpal tunnel. In a PR-2 dated 10-13-15, the injured worker complained of persistent pain to the mid back, bilateral shoulders and bilateral wrists associated with numbness and weakness. The injured worker rated her pain 8 to 9 out of 10 on the visual analog scale. The injured worker stated that Tylenol #3 was not helping but Neurontin decreased her pain from 8 to 3 or 4 out of 10. Physical exam was remarkable for cervical spine with tenderness to palpation, loss of range of motion, positive cervical compression and Spurling's tests and decreased sensation at the right C5 to C8 distribution, bilateral shoulder with tenderness to palpation, 4+ out of 5 strength with flexion and adduction, lumbar spine with tenderness to palpation, hypertonicity and loss of range of motion and bilateral wrists with "decreased" range of motion and "decreased" right grip strength at 4 out of 5. The treatment plan included laboratory studies to rule out a rheumatologic disorder and right endoscopic carpal tunnel release as recommended by the orthopedist and new prescriptions for Norco and Flexeril due to worsening pain and the fact that Tylenol #3 was not helping. On 11-2-15,

Utilization Review noncertified a request for a right endoscopic carpal tunnel release and Flexeril 10mg #90 and modified a request for Norco 5-325mg #90 to Norco 5-325mg #45.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right Endoscopic carpal tunnel release: Upheld

Claims Administrator guideline: Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004, Section(s): Surgical Considerations.

MAXIMUS guideline: Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004, Section(s): Diagnostic Criteria, Physical Methods, Surgical Considerations, Summary.

Decision rationale: The patient is a 30 year old female with signs and symptoms of a possible right carpal tunnel syndrome. She has undergone conservative management of medications, splinting and a previous carpal tunnel injection with no relief or response. Electrodiagnostic studies are reported to be normal. From page 261, ACOEM, Chapter 11, Appropriate electrodiagnostic studies (EDS) may help differentiate between CTS and other conditions, such as cervical radiculopathy. These may include nerve conduction studies (NCS), or in more difficult cases, electromyography (EMG) may be helpful. NCS and EMG may confirm the diagnosis of CTS but may be normal in early or mild cases of CTS. If the EDS are negative, tests may be repeated later in the course of treatment if symptoms persist. From page 265, Chapter 11, Symptomatic relief from a cortisone/anesthetic injection will facilitate the diagnosis; however, the benefit from these injections is short-lived. From page 270, ACOEM, Chapter 11, "Surgical decompression of the median nerve usually relieves CTS symptoms. High-quality scientific evidence shows success in the majority of patients with an electrodiagnostically confirmed diagnosis of CTS. Patients with the mildest symptoms display the poorest post surgery results; patients with moderate or severe CTS have better outcomes from surgery than splinting. CTS must be proved by positive findings on clinical examination and the diagnosis should be supported by nerve-conduction tests before surgery is undertaken. Mild CTS with normal electrodiagnostic studies (EDS) exists, but moderate or severe CTS with normal EDS are very rare." Further from page 272, Table 11-7, injection of corticosteroids into the carpal tunnel is recommended in mild to moderate cases of carpal tunnel syndrome after trial of splinting and medication. Therefore, as the steroid injection did not appear to confirm the diagnosis and that previous EDS studies were negative, right carpal tunnel release should not be considered medically necessary. EDS could be repeated to see if there is a change in the patient's condition. The request is not medically necessary.

Norco (Hydrocodone 5/325mg) #90: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain.

Decision rationale: The patient is a 30 year old female who has evidence of chronic pain in the back, neck, and wrists. Her pain was noted to be persistent, worsening and not controlled with Tylenol #3. A request was made to switch to a stronger narcotic given this worsening condition, as well as an increased frequency of Flexeril. Based on this acute exacerbation, this should be considered medically necessary. From page 89, Long term users of opioids, the following is recommended: Strategy for maintenance: (a) Do not attempt to lower the dose if it is working: (b) Supplemental doses of break-through medication may be required for incidental pain, end-of-dose pain, and pain that occurs with predictable situations. This can be determined by information that the patient provides from a pain diary or evaluation of additional need for supplemental medication. (c) The standard increase in dose is 25 to 50 percent for mild pain and 50 to 100 percent for severe pain (Wisconsin). Thus, the switch to Norco can be considered a break-through medication and is medically necessary. Further use of this medication should be considered for maintenance therapy. The UR stated that there was a lack of documentation of pain relief and side effects, physical and psychosocial functioning or any drug related behavior. The request was partially certified for Norco to allow for clarification. Based on the provided documentation, this has been clarified as this is an acute worsening of her symptoms.

Flexeril (Cyclobenzaprine HCL) 10mg #90: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Muscle relaxants (for pain).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Cyclobenzaprine (Flexeril).

Decision rationale: The patient is a 30 year old female who has evidence of chronic pain in the back, neck and wrists. Her pain was noted to be persistent, worsening and not controlled with Tylenol #3. A request was made to switch to a stronger narcotic given this worsening condition, as well as an increased frequency of Flexeril. Based on this acute exacerbation, this should be considered medically necessary. Although the patient had previously been on Flexeril, this is an acute exacerbation and Flexeril can be considered for use in this manner with an increased frequency. From page 41, Chronic Pain Medical treatment guidelines: Recommended as an option, using a short course of therapy. See Medications for chronic pain for other preferred options. Cyclobenzaprine (Flexeril) is more effective than placebo in the management of back pain; the effect is modest and comes at the price of greater adverse effects. The effect is greatest in the first 4 days of treatment, suggesting that shorter courses may be better (Browning, 2001). Treatment should be brief. Based on this acute exacerbation, the increased frequency should be considered from a brief course and thus medically necessary. The UR stated that there is not a rationale documented for use. However, based on the medical records provided for this review, the lack of a rationale issue appears to have been satisfied. The request is medically necessary.