

Case Number:	CM15-0056983		
Date Assigned:	04/01/2015	Date of Injury:	10/05/2012
Decision Date:	05/18/2015	UR Denial Date:	03/06/2015
Priority:	Standard	Application Received:	03/25/2015

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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 49-year-old female who reported an injury on 10/05/2012. The mechanism of injury was not specifically stated. The current diagnoses include impingement syndrome of the right shoulder with bicipital tendinitis, discogenic cervical condition, cubital tunnel syndrome, radial tunnel syndrome, carpal tunnel syndrome, carpometacarpal joint inflammation of the thumb, impingement syndrome along the left shoulder, stenosing tenosynovitis along the index and long fingers on the right, and chronic pain syndrome. The injured worker presented on 02/20/2015 for a followup evaluation with complaints of persistent pain. It was noted that the injured worker was status post injection at the first extensor. The injured worker reported issues with GERD, sleep, and depression. In addition, the injured worker was status post right carpal tunnel release in 2011 and left carpal tunnel release on 01/15/2015. The injured worker reported persistent triggering along the right long finger. Previous nerve conduction studies have been positive prior to surgery with residual carpal tunnel syndrome on the right. Upon examination, there was tenderness along the carpal tunnel and first extensor with weakness against resistance. Treatment recommendations at that time included a fluoroscopy evaluation of the wrist, continuation of a current medication regimen, a referral for suicidal ideation, and a course of physical therapy. A Request for Authorization form was submitted on 02/20/2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Fluoroscopy of the left wrist: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Rubin DA, Weissman BN, Appel M, Arnold E, Bencardino JT, Fries IB, Hayes CW, Hochman MG, Jacobson JA, Luchs JS, Math KR, Murphey MD, Newman JS, Scharf SC, Small KM, Expert Panel on Musculoskeletal Imaging. ACR Appropriateness criteria Chronic wrist pain. Reston (VA): American College of Radiology (ACR); 2012.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 268-269.

Decision rationale: The California MTUS/ACOEM Practice Guidelines state for most patients presenting with true hand and wrist problems, special studies are not needed until after a 4 to 6 week period of conservative care and observation. In this case, there was evidence of wrist tenderness. However, there was no documentation of instability upon examination. There was no mention of plain films obtained prior to the request for fluoroscopy. Additionally, there was no indication that this request for fluoroscopy will be used for guidance during an injection procedure or as an adjunct to an additional imaging study, such as an arthrography. The medical rationale for the requested service was not provided within the documentation. Given the above, the request is not medically appropriate.

12 physical therapy visits: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99.

Decision rationale: The California MTUS Guidelines state active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. In this case, the injured worker's physical examination revealed tenderness to palpation with weakness against resistance. There was no documentation of the previous course of physical therapy with evidence of objective functional improvement to support the necessity for additional treatment. The request as submitted failed to indicate a specific body part to be treated. Given the above, the request is not medically appropriate.

Protonix 10mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk.

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

Decision rationale: The California MTUS Guidelines state proton pump inhibitors are recommended for patients at intermediate or high risk for gastrointestinal events. Patients with no risk factor and no cardiovascular disease do not require the use of a proton pump inhibitor, even in addition to a nonselective NSAID. In this case, there was no documentation of cardiovascular disease or increased risk factors for gastrointestinal events. The medical necessity for the requested medication has not been established. Additionally, there is no frequency listed in the request. As such, the request is not medically appropriate.

Nalfon 400mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Fenoprofen (Nalfon, generic available).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67-72.

Decision rationale: The California MTUS Guidelines state NSAIDs are recommended for osteoarthritis at the lowest dose for the shortest period in patients with moderate to severe pain. For acute exacerbations of chronic pain, NSAIDs are recommended as a second line option after acetaminophen. In this case, it was noted that the injured worker has continuously utilized NSAIDs since 07/2014. The guidelines do not support long term use of NSAIDs. There was no evidence of an acute exacerbation of chronic pain. The California MTUS Guidelines indicate Nalfon is used for osteoarthritis and off label for ankylosing spondylitis. The injured worker does not maintain either of the above mentioned diagnoses. Furthermore, there was no frequency listed in the request. Given the above, the request is not medically appropriate.

1 consultation for psyche: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 397.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 89-92.

Decision rationale: The California MTUS/ACOEM Practice Guidelines state a referral may be appropriate if the practitioner is uncomfortable with the line of inquiry, with treating a particular cause of delayed recovery, or has difficulty obtaining information or an agreement to a treatment plan. It was noted that the injured worker was referred for a psychological evaluation secondary to suicidal ideation. However, the injured worker has been previously issued authorization for 1 psychiatry referral between 02/2015 and 03/2015. The medical necessity for an additional referral has not been established in this case. As such, the request is not medically appropriate at this time.