

<b>Case Number:</b>	CM14-0119080		
<b>Date Assigned:</b>	08/06/2014	<b>Date of Injury:</b>	10/05/2012
<b>Decision Date:</b>	11/14/2014	<b>UR Denial Date:</b>	07/14/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/29/2014

### 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:

The patient is a 48 year old female who sustained an industrial injury on 10/5/2012. Review of the medical records indicates the patient is being treated for multiple chronic musculoskeletal complaints. She is not working. A 6/19/2013 electrodiagnostic study indicated mild bilateral median nerve compression, affecting only the sensory component; chronic neuropathic changes in the thenar musculature of both hands that suggests the median nerve compression at the wrists was previously much more severe and involved motor axons; no evidence of cervical radiculopathy. The 7/23/2014 progress report indicates the patient presents routine follow up for bilateral hands and wrists. Recent 7/10/2014 MRI studies of the cervical and shoulders are reviewed. She has persistent pain in the hands along the carpal tunnel with numbness, tingling and weakness with gripping/grasping. She has braces and cold wrap. Left carpal tunnel release (CTR) is requested. Objective findings indicate tenderness; positive Tinel's at the right wrist and into the left thumb/index, decreased sensation along the right radial distribution, and positive reverse Phalen's and negative Phalen's bilaterally. There are 8 diagnoses listed. She is not working. She is provided prescriptions for Norco, Gabapentin, Tramadol ER 100mg, Protonix, Naproxen, and Trazodone for insomnia. Cervical pillow for sleep is also requested.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Carpal tunnel surgery on the left: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 265. Decision based on Non-MTUS Citation Official Disability Guidelines, Indications for Surgery-Carpal Tunnel Release

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 270. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Carpal Tunnel Syndrome, Carpal tunnel release surgery (CTR)

**Decision rationale:** According to the guidelines, surgical decompression of the median nerve usually relieves carpal tunnel syndrome (CTS) symptoms. High-quality scientific evidence shows success in the majority of patients with an electrodiagnostically confirmed diagnosis of CTS. Request is made for left CTR; however, the medical records do not indicate a current or recent EMG/NCV study that reveals moderate or worse CTS in the left wrist. In addition, the physical objective findings are not indicative of CTS of at least moderate severity. It is not established that the patient is a candidate for the proposed surgery. The medical necessity for left CTR has not been established.

**Preoperative History and Physical, Complete Blood Count, Comprehensive Metabolic Panel and Urinalysis:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back - Lumbar & Thoracic (Acute & Chronic)

**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, Preoperative testing, general

**Decision rationale:** The medical necessity of left CTR has not been established. Therefore, there is no medical necessity for any pre-operative clearance studies/labs.

**MRI of Both Wrists:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 42.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 269. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, Wrist and Hand, MRI's (magnetic resonance imaging)

**Decision rationale:** According to the California MTUS/ACOEM, "For most patients presenting with true hand and wrist problems, special studies are not needed until after a four- to six-week period of conservative care and observation. Most patients improve quickly, provided red flag conditions are ruled out." The medical records do not support the request for MRI of the left wrist. There is no indication the patient is a surgical candidate or pending surgery. She is treating for diagnosis of carpal tunnel syndrome. The patient's wrist complaint is not acute, she has not

sustained any recent trauma, and the medical records do not document results of plain films. In addition, physical examination findings do not suggest soft tissue tumor or Keinbocks's disease. Consequently, MRI studies of the wrists are not medical necessity.

**Bilateral Braces:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 264.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 265. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Carpal Tunnel Syndrome, Splinting

**Decision rationale:** The guidelines state, when treating with a splint in CTS, scientific evidence supports the efficacy of neutral wrist splints. Splinting should be used at night, and may be used during the day, depending upon activity. Splinting after surgery has negative evidence. According to the medical records, the patient already has day and night braces. She is status post right carpal tunnel syndrome, and postoperatively, bracing is not recommended. There is no medically supportive basis for the request for bilateral braces. Therefore, this request is not medically necessary.

**Cervical Pillow:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper Back, (Acute & Chronic)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck, Pillow

**Decision rationale:** According to the Official Disability Guidelines, the guidelines recommend use of a neck support pillow while sleeping, in conjunction with daily exercise. This RCT concluded that subjects with chronic neck pain should be treated by health professionals trained to teach both exercises and the appropriate use of a neck support pillow during sleep; either strategy alone did not give the desired clinical benefit. In the case of this patient, there is no evidence she utilizes an HEP. The medical records also do not support that instruction and routine use of appropriate daily exercises and the appropriate use of a neck support pillow have been discussed and would be implemented. Just providing a cervical pillow does not provide clinical benefit, and is not recommended as medically necessary.

**Amoxicillin 875mg:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation National Guidelines Clearinghouse, National Collaborating Centre for Women's and Children's Health. National Institute for Health and Clinical Excellence 2008 Oct. 142p.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Medline Plus - Amoxicillin  
<http://www.nlm.nih.gov/medlineplus/druginfo/meds/a685001.html>

**Decision rationale:** Amoxicillin is used to treat certain infections caused by bacteria, such as pneumonia; bronchitis; gonorrhea; and infections of the ears, nose, throat, urinary tract, and skin. Amoxicillin is in a class of medications called penicillin-like antibiotics. It works by stopping the growth of bacteria. The requested surgery has not been recommended as medically necessary. Therefore, post-operative antibiotic prophylaxis is not medically necessary.

**Zofran 10mg:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain (Chronic)

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

**Decision rationale:** According to Official Disability Guidelines, Ondansetron (Zofran) is a serotonin 5-HT<sub>3</sub> receptor antagonist, FDA-approved for nausea and vomiting secondary to chemotherapy and radiation treatment. It is also FDA-approved for postoperative use. The request for left CTR is not deemed medically necessary. Therefore, there is no medical necessity for postoperative medications.

**Neurontin 600mg:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin (Neurontin) Page(s): 49.

**Decision rationale:** The guidelines state Gabapentin (Neurontin) is an anti-epilepsy drug (AEDs - also referred to as anticonvulsants), which has been shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first-line treatment for neuropathic pain. The 6/23/2014 progress report appears to indicate that the request is for Neurontin 600 #90. However, it is not been clarified if any other physicians are prescribing gabapentin, and if she has used Gabapentin in the past, and provide details regarding the patient's response to use of this medication. Consequently, further clarification of the request is needed. The medical necessity of the request has not been established at this time.

**Flexeril 5mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril) Page(s): 41, 64.

**Decision rationale:** According to the guidelines, antispasmodics are used to decrease muscle spasms. Flexeril is recommended as an option, using a short course. The medical records do not document the presence of muscle spasm on examination. The guidelines state muscle relaxants seem no more effective than NSAIDs for treating patients with musculoskeletal problems, and using them in combination with NSAIDs has no demonstrated benefit. The patient's medication regimen includes NSAIDs. The addition of cyclobenzaprine to other agents is not recommended. Further, the medical records indicate the patient has been chronically treating with Flexeril, which is not recommended. Ongoing use of Flexeril is not medically necessary.

**Restoril #30:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain (Chronic)

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Insomnia treatment

**Decision rationale:** According to the guidelines, Benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there is a risk of psychological and physical dependence or frank addiction. The Official Disability Guidelines states Restoril is FDA-approved benzodiazepines for sleep maintenance insomnia. These medications are only recommended for short-term use due to risk of tolerance, dependence, and adverse events (daytime drowsiness, anterograde amnesia, next-day sedation, impaired cognition, impaired psychomotor function, and rebound insomnia). These drugs have been associated with sleep-related activities such as sleep driving, cooking and eating food, and making phone calls (all while asleep). Particular concern is noted for patients at risk for abuse or addiction. Withdrawal occurs with abrupt discontinuation or large decreases in dose. Decrease slowly and monitor for withdrawal symptoms. Benzodiazepines are a major cause of overdose, particularly as they act synergistically with other drugs. The guidelines states Benzodiazepines are the treatment of choice in very few conditions. Tolerance to anxiolytic effects occurs within months and long-term use may actually increase anxiety. The patient has been maintained on this medication for an extensive duration, which is not supported by the guidelines. In addition, quantifiable and clinically significant improvement with use has not been demonstrated. The medical necessity of continuing Restoril is not established.