

<b>Case Number:</b>	CM14-0136504		
<b>Date Assigned:</b>	09/03/2014	<b>Date of Injury:</b>	04/01/2007
<b>Decision Date:</b>	10/06/2014	<b>UR Denial Date:</b>	08/20/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/25/2014

### 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:

65 year old female claimant with an industrial injury dated 04/01/07. Exam note 08/06/14 states the patient returns with shoulder, bilateral wrist, and hand pain in which she rated a 6/10. The patient reports having frequent spasms, numbness, and tingling in the shoulders and hands. She uses a wrist brace but reports issues with gripping and grasping. Current medications include Trazadone, Fexeril, and Prilosec. In the physical exam the patient demonstrated a reduced range of motion in the neck, shoulder, and wrist. MRI left wrist demonstrates no evidence of tendinous or ligamentous disruption from 12/26/12. The patient is status post decompression of the right, carpometacarpal joint inflammation bilaterally in which is worse on the left, sleep issues and depression. Treatment includes a continuation of medication and left wrist surgery involving abrasion of arthroplasty.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **1 Left wrist surgery involving abrasion of arthroplasty: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 270.

**Decision rationale:** CA MTUS/ACOEM Chapter 11, recommends referral for hand surgery for patients with red flags, failure to respond to conservative management and have clear clinical and special study evidence of a lesion that has been shown to benefit, in both the short and long term, from surgical Intervention. In this case the exam note from 8/6/14 does not demonstrate evidence of failure of conservative management with bracing, activity modification or injection. In addition there is no clear surgical lesion on MRI from 12/26/12 to warrant surgical care. Therefore the request is not medically necessary.

**request for Unkown pre-op items:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**1 prescription of Trazodine 50mg #60:** 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); Non-Benzodiazepine-receptor agonists; Official Disability guidelines, Pain (Chronic); Trazodone ; regarding Insomnia Treatment

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants Page(s): 13.

**Decision rationale:** Trazadone is a atypical antidepressant. According to the CA MTUS Chronic Pain guidelines, page 13, antidepressants are used as first line option for neuropathic pain or possibly for non neuropathic pain. There is no evidence in the records of depression or insomnia in the records from 8/6/14 to justify Trazadone. Therefore the request is not medically necessary.

**1 prescription of Trazodone 50mg #60:** 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); Non-Benzodiazepine-receptor agonists; Official Disability guidelines, Pain (Chronic); Trazodone ; regarding Insomnia Treatment

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants Page(s): 13.

**Decision rationale:** Trazadone is a typical antidepressant. According to the CA MTUS Chronic Pain guidelines, page 13, antidepressants are used as first line option for neuropathic pain or

possibly for non-neuropathic pain. There is no evidence in the records of depression or insomnia in the records from 8/6/14 to justify Trazadone. Therefore the request is not medically necessary.

**1 prescription of Flexeril 5mg #60: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines (May 2009); Flexeril (cy.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine Page(s): 41-42.

**Decision rationale:** According to the CA MTUS, Chronic Pain Medical Treatment Guidelines, Cyclobenzaprine, pages 41-42 "Recommended as an option, using a short course of therapy. 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. There is also a post-op use. The addition of cyclobenzaprine to other agents is not recommended." In this particular case the patient has no evidence in the records of 8/6/14 of functional improvement, a quantitative assessment on how this medication helps, percentage of relief lasts, increase in function, or increase in activity. Therefore chronic usage is not supported by the guidelines. Therefore the request is not medically necessary.

**1 prescription of Prilosec 20mg #60: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines (May 2009); regarding Pr.

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

**Decision rationale:** Per the CA MTUS Chronic Pain Medical Treatment Guidelines, page 68, recommendation for Prilosec is for patients with risk factors for gastrointestinal events. The cited records from 8/6/14 do not demonstrate that the patient is at risk for gastrointestinal events. Therefore, the requested Prilosec is not medically necessary.