

<b>Case Number:</b>	CM15-0013015		
<b>Date Assigned:</b>	01/30/2015	<b>Date of Injury:</b>	04/02/2014
<b>Decision Date:</b>	03/19/2015	<b>UR Denial Date:</b>	01/14/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/22/2015

### 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, Ohio, California  
 Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

### 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 33 year old female, who sustained a work/ industrial injury on 4/2/14 while carrying a metal pitcher of water as a server in a restaurant. She has reported symptoms of sudden onset of pain in the left wrist, elbow, and shoulder. Past medical history included ulcer, Crohn's disease, blood clots, depression, an anxiety. The diagnoses have included left wrist: De Quervain tenosynovitis, and left shoulder strain. Examination noted general tenderness over the shoulder, elbow, and wrist without evidence of weakness, atrophy, or significant limitation of motion. Impingement tests were positive at the left shoulder and Finkelstein's test was positive at the left hand. X-ray's demonstrated no osseous abnormalities, first extensor compartment tendonitis with some atypical features, and biceps tendon strain and bicep muscle strain. MRI on 10/13/14 of the left wrist noted no joint effusion, normal tendons, no evidence of tendinopathy or tenosynovitis. Treatment to date has included conservative measures, physical therapy, acupuncture, activity modification, and medication. A request was made for Relafen, MRI of the left wrist, and Functional Neuromuscular Stimulator. On 1/14/15, Utilization Review non-certified Relafen, MRI of left wrist; and Functional Neuromuscular Stimulator, noting the California Medical treatment Utilization Schedule (MTUS) for the Relafen and Functional Neuromuscular Stimulator and American College of Occupational and Environmental Medicine (ACOEM) Guidelines for the MRI testing.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Relafen:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS (Non-Steroidal Anti-Inflammatory Drugs) Page(s): 47.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-inflammatory medications Page(s): Chronic Pain Medical Treatment Guidelines 8 C.C.R. 9792.2.

**Decision rationale:** The applicant is a represented [REDACTED] employee who has filed a claim for chronic neck, shoulder, wrist, and hand pain reportedly associated with an industrial injury of April 2, 2014. In a Utilization Review Report dated January 14, 2015, the claims administrator failed to approve requests for Relafen, MRI imaging of the wrist, and a neuromuscular stimulator. The applicant's attorney subsequently appealed. In a January 19, 2015 letter, the applicant's attorney appealed the denial. The applicant's attorney stated that the applicant needed the treatment at issue to continue working. Thus, the applicant's attorney suggested (but did not clearly state) that the applicant was working. In a January 5, 2015 progress note, the applicant reported 7-8/10 hand, wrist, and upper extremity pain. The applicant was reportedly working on a part-time basis, the treating provider stated. The applicant was apparently transferring care to a new primary treating provider at the request of her attorney. The applicant was apparently working anywhere from 18 to 33 hours a week as a serving assistant at a restaurant. The applicant exhibited tenderness about the left wrist triangular fibrocartilage region. 5/5 left upper extremity strength was appreciated. Positive signs of internal impingement were noted about the left shoulder with 125 to 130 degrees of left shoulder flexion and abduction appreciated. The attending provider stated that the applicant needed MRI imaging of the wrist and shoulder to search for any underlying significant pathology. Work restrictions were endorsed. Pamelor and Relafen were also endorsed, along with an electrical muscle stimulator/neuromuscular electrical stimulator. The requesting provider was a physiatrist. REFERRAL QUESTIONS:1. Yes, the request for Relafen, an anti-inflammatory medication, was medically necessary, medically appropriate, and indicated here. As noted on page 22 of the MTUS Chronic Pain Medical Treatment Guidelines, anti-inflammatory medications such as Relafen do represent the traditional first line of treatment for various chronic pain conditions, including the chronic pain syndrome reportedly present here. The request in question did seemingly represent a first-time request for Relafen, introduced on the ground that the applicant had developed dyspepsia with ibuprofen. Introduction of Relafen was, thus, indicated on or around the date in question, January 5, 2015. Therefore, the request was medically necessary. REFERENCES:MTUS Chronic Pain Medical Treatment Guidelines, page 22, Anti-Inflammatory Medications topic.

**MRI (Magnetic Resonance Imaging) 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 Official Disability Guidelines (ODG), Indications for Imaging

**MAXIMUS guideline:** Decision based on MTUS ACOEM Page(s): 272.

**Decision rationale:** 2. Conversely, the request for MRI imaging of the left wrist was not medically necessary, medically appropriate, or indicated here. While the MTUS Guideline in ACOEM Chapter 11, Table 11-7, page 272 does acknowledge that MRI imaging of the wrist is "optional" prior to a history and physical examination by qualified specialist, in this case, however, the attending provider did not furnish much in the way of the applicant-specific rationale or narrative commentary so as to augment the tepid ACOEM position on the article at issue. It was not stated how the proposed wrist MRI would influence or alter the treatment plan. The requesting provider was a physiatrist, not a hand surgeon, reducing the likelihood of the applicant's acting on the results of the proposed wrist MRI and/or considering surgical intervention based on the outcome of the same. Therefore, the request was not medically necessary. REFERENCES:ACOEM Practice Guidelines, Chapter 11, Table 11-7, page 272.

**Functional Neuromuscular Stimulator:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Neuromuscular Electrical Stimulation (NMES Devices).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Neuromuscular electrical stimulation (NMES devices) Page(s): Chronic Pain Medical Treatment Guid.

**Decision rationale:** 3. Finally, the request for functional neuromuscular stimulator (AKA neuromuscular electrical stimulator) was likewise not medically necessary, medically appropriate, or indicated here. As noted on page 121 of the MTUS Chronic Pain Medical Treatment Guidelines, neuromuscular electrical stimulator, the modality at issue, is not recommended in the chronic pain context present here but, rather, should be reserved for the post stroke rehabilitation context. Here, however, there was no mention of the applicant's having previously suffered a stroke. Therefore, the request for a functional neuromuscular stimulator was not medically necessary. REFERENCES:MTUS Chronic Pain Medical Treatment Guidelines, page 121, Neuromuscular Electrical Stimulation topic.