

<b>Case Number:</b>	CM15-0116490		
<b>Date Assigned:</b>	06/22/2015	<b>Date of Injury:</b>	05/26/2005
<b>Decision Date:</b>	07/23/2015	<b>UR Denial Date:</b>	06/05/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/16/2015

### 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: New Jersey, Alabama, California  
 Certification(s)/Specialty: Neurology, Neuromuscular 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 52 year old female, who sustained an industrial injury on 5/26/05. She reported initial complaints of neck injury. The injured worker was diagnosed as having enthesopathy wrist/carpus; sprain elbow/forearm; sprain hand; lumbosacral sprain; neck sprain; right ulnar nerve neuritis; traumatic musculoligamentous strain cervical spine; cervical spondylosis; discogenic disease at C3-4, C4-5 and C5-6; carpal tunnel syndrome right. Treatment to date has included physical therapy; acupuncture; urine drug screening; medications. Diagnostics included MRI cervical spine (3/24/10); EMG/NCV study bilateral upper extremities (4/7/10). Currently, the PR-2 notes dated 5/14/15 indicated the injured worker complains of increased pain and discomfort in the lumbar spine and lower extremities. He cannot do heavy lifting, repetitive bending and stooping activities. He has had prior injection by another provider which only provided symptomatic relief. He also complains of his cervical spine indicating the pain in the neck area has been causing an increase in headaches. The pain is more or less constant in nature in the cervical spine and repetitive flexion and extension increased the pain. He uses a cane in the left hand because using his right hand causes increased pain and numbness in the ulnar three fingers. He has difficulty sleeping at night because the right arm swells and causes throbbing pain and because of his lumbar pain. He reports an increased weakness with gripping and grasping. On physical examination of the lumbar spine, palpation notes tenderness over the paraspinal muscles. There is also muscle spasms and guarding. His range of motion is decreased with forward flexion at 30 degrees; extension at 20 degrees and side-to-side bending at 15 degrees. The cervical spine exam notes palpation with tenderness over the paracervical

muscles with spasm and guarding and special test note positive axial compression test. The right upper extremity exam notes tenderness on palpation over the right wrist and right elbow region. There is subluxation of the ulnar nerve which is painful and tender. Special test included Tinel's which was positive for ulnar nerve neuritis. Positive Tinel's for right carpal tunnel syndrome. The neurological exam notes hypoesthesia over the ulnar two fingers, sometimes affecting the third finger. The provider had requested an ulnar nerve anterior transposition which has been approved. He also requested authorization at an Outpatient at surgery center; post-operative physical therapy visits and Norco 7.5/325mg #60.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Outpatient at surgery center:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Carpal Tunnel Syndrome-Hospital length of stay.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Surgery for cubital tunnel syndrome (ulnar nerve entrapment), <http://www.odg-twc.com/index.html>.

**Decision rationale:** According to ODG guidelines: ODG Indications for Surgery -- Surgery for cubital tunnel syndrome: Initial conservative treatment, requiring ALL of the following: (1) Exercise: Strengthening the elbow flexors/extensors isometrically and isotonicly within 0-45 degrees (2) Activity modification: Recommend decreasing activities of repetition that may exacerbate the patient's symptoms. Protect the ulnar nerve from prolonged elbow flexion during sleep, and protect the nerve during the day by avoiding direct pressure or trauma. (3) Medications: Non-steroidal anti-inflammatory drugs (NSAIDs) in an attempt to decrease inflammation around the nerve. (4) Pad/splint: Use an elbow pad and/or night splinting for a 3-month trial period. Consider daytime immobilization for 3 weeks if symptoms do not improve with splinting. If the symptoms do improve, continue conservative treatment for at least 6 weeks beyond the resolution of symptoms to prevent recurrence. The patient developed an ulnar neuropathy that could benefit from an ulnar transposition. This could be done at any outpatient surgery center and not in a specific surgery center. Therefore, the request for the surgery to be done in a specific surgery center is not medically necessary.

**Norco 7.5/325mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Weaning of Medications Page(s): 75, 78, 124.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of opioids Page(s): 76-79.

**Decision rationale:** According to MTUS guidelines, Norco (Hydrocodone/Acetaminophen) is a synthetic opioid indicated for the pain management but not recommended as a first line oral analgesic. In addition and according to MTUS guidelines, ongoing use of opioids should follow specific rules: (a) Prescriptions from a single practitioner taken as directed, and all prescriptions from a single pharmacy. (b) The lowest possible dose should be prescribed to improve pain and function. (c) Office: Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non adherent) drug-related behaviors. These domains have been summarized as the "4As" (analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework. According to the patient's file, there is no objective documentation of pain and functional improvement to justify continuous use of Norco. Norco was used for longtime without documentation of functional improvement or improvement of activity of daily living. Therefore, the prescription of Norco 7.5/325mg #54 is not medically necessary.

**12 post-operative physical therapy visits:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines  
Physical Medicine Page(s): 98.

**Decision rationale:** According to MTUS guidelines, Physical Medicine is "Recommended as indicated below. Passive therapy (those treatment modalities that do not require energy expenditure on the part of the patient) can provide short term relief during the early phases of pain treatment and are directed at controlling symptoms such as pain, inflammation and swelling and to improve the rate of healing soft tissue injuries. They can be used sparingly with active therapies to help control swelling, pain and inflammation during the rehabilitation process. 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. Active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy may require supervision from a therapist or medical provider such as verbal, visual and/or tactile instruction(s). Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. (Colorado, 2002) (Airaksinen, 2006) Patient-specific hand therapy is very important in reducing swelling, decreasing pain, and improving range of motion in CRPS. (Li, 2005) The use of active treatment modalities (e.g., exercise, education, activity modification) instead of passive treatments is associated with substantially better clinical outcomes. In a large case series of patients with low back pain treated by physical therapists, those adhering to guidelines for active rather than passive treatments incurred fewer treatment visits, cost less, and had less pain and less disability. The overall success rates were 64.7% among those adhering to the active treatment recommendations versus 36.5% for passive treatment. (Fritz, 2007)." In this case, the frequency of the treatment should be

reduced from 12 to 3 or less sessions. More sessions will be considered when functional and objective improvement is documented. Therefore, the request for 12 post-operative physical therapy visits is not medically necessary.