

<b>Case Number:</b>	CM15-0162872		
<b>Date Assigned:</b>	09/04/2015	<b>Date of Injury:</b>	03/14/2012
<b>Decision Date:</b>	12/31/2015	<b>UR Denial Date:</b>	08/06/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/19/2015

### 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 York, California  
 Certification(s)/Specialty: Emergency 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:

This injured worker is a 53-year-old male who reported an industrial injury on 3-14-2012. His diagnoses, and or impressions, were noted to include: limb pain; cervical sprain-strain with radiculopathy; lumbar sprain-strain with lumbosacral radiculopathy; carpal tunnel syndrome; shoulder sprain-strain, with impingement. No imaging studies were noted; magnetic resonance imaging studies of the cervical and lumbar spine, and right shoulder were noted done on 2-7-2013, noting abnormal findings. His treatments were noted to include: physical therapy (2013); medication management with toxicology studies (4-28-15); and rest from work. The progress notes of 5-8-2013 reported: that he was hitting a brick wall due to all components of requested treatments being denied, along with the physicians understanding to the denials and challenge to the guidelines. No objective findings were noted. The physician's request for treatment was for the continuation of his current medications. No Request for Authorization for: Gabapentin 300 mg, #100, from date of service (DOS) 10-10-12, 2-27-13 & 5-8-13; Hydrocodone 10-325 mg, #30, from DOS 10-10-12, 5-8-13 & #30 from 2-27-13; Norflex from DOS 10-10-12; Sertraline Hydrochloride 50 mg, #30, from DOS 1-16-13 & 3-27-13; Norflex 100 mg, #100, from DOS 2-27-13 & 5-8-13; Omeprazole 20 mg, #90, from DOS 10-10-12 & 1-16-13; Nabumetone 750 mg, #100, from DOS 1-16-13 & 2-27-13; and the purchase of a wrist support from DOS 1-16-13 was not noted in the medical records provided. The Utilization Review of 8-06-2015 non-certified the requests for: Gabapentin 300 mg, #100, from date of service (DOS) 10-10-12, 2-27-13 & 5-8-13; Hydrocodone 10-325 mg, #30, from DOS 10-10-12, 5-8-13 & #30 from 2-27-13; Norflex from DOS 10-10-12; Sertraline Hydrochloride 50 mg, #30, from DOS 1-16-13 & 3-27-

13; Norflex 100 mg, #100, from DOS 2-27-13 & 5-8-13; Omeprazole 20 mg, #90, from DOS 10-10-12 & 1-16-13; Nabumetone 750 mg, #100, from DOS 1-16-13 & 2-27-13; and the purchase of a wrist support from DOS 1-16-13.

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

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

**Retro (DOS 10/10/12, 2/27/13, 5/8/13) Gabapentin 300mg #100: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antiepilepsy drugs (AEDs).

**Decision rationale:** According to CA MTUS, gabapentin is an anti-epilepsy drug which has efficacy for diabetic neuropathy or post-herpetic neuropathy. It has also been considered a first line agent for neuropathic pain. There is not sufficient evidence to recommend the use of these medications for the treatment of chronic non-specific, non-neuropathic axial low back pain. Ongoing use of these medications recommends "documentation of pain relief and improvement in function as well as documentation of side effects incurred with use. The continued use of AEDs depends on improved outcomes versus tolerability of adverse effects." The IW has been prescribed this medication on an ongoing basis. The records submitted do not support improvement of symptoms or function with the use of this medication. Documentation from the retrospective date of treatment were not included for review. Additionally, the request does not include dosing or frequency. Without this documentation, the request for gabapentin is not medically necessary in accordance with MTUS guidelines.

**Retro (DOS 10/10/12, 5/8/13): Hydrocodone BIT/APAP 10/325mg #30: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain, Opioids, specific drug list.

**Decision rationale:** CA MTUS, chronic pain guidelines, offer very specific guidelines for the ongoing use of narcotic pain medication to treat chronic pain. These recommendations state that the lowest possible dose be used as well as "ongoing review and documentation of pain relief, functional status, appropriate medication use and its side effects." It also recommends that providers of opiate medication document the injured worker's response to pain medication including the duration of symptomatic relief, functional improvements, and the level of pain relief with the medications. The included documentation fails to include the above recommended documentation. The IW has been prescribed this medication on an ongoing basis. The records submitted do not support improvement of symptoms or function with the use of this medication. Documentation from the retrospective date of treatment were not included for

review. Additionally, the request does not include dosing or frequency. Without this documentation, the request for hydrocodone is not medically necessary in accordance with MTUS guidelines.

**Retro (DOS 10/10/12, 01/16/13): Omeprazole 20mg #90: 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), Pain Chapter, Proton Pump Inhibitors (PPIs), NSAIDS, GI Symptoms & cardiovascular risk.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk.

**Decision rationale:** According to CA MTUS, gastrointestinal protectant agents are recommended for patients that are at increased risk for gastrointestinal events. These risks include age >65, history or gastrointestinal bleeding or peptic ulcers, concomitant use of NSAIDs and corticosteroids or aspirin, or high dose NSAID use. The chart does not document any of these risk factors. Past medical history does not include any gastrointestinal disorders, there is no history of poor tolerance to NSAIDs documented and there are not abdominal examinations noted in the chart. Documentation from the retrospective date of treatment were not included for review. The request does not include frequency or dosing. Omeprazole is not medically necessary based on the MTUS.

**Retro (DOS 2/27/13/, 5/8/13, 10/10/12) Norflex 100mg #100: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Muscle relaxants (for pain).

**Decision rationale:** The CA MTUS for Chronic Pain does not recommend muscle relaxants for chronic pain. Non-sedating muscle relaxants are an option for short term exacerbation of chronic low back pain. This patient has chronic pain with no evidence of prescribing for flare-ups, and the pain is in the extremity, not the low back. Prescribing was not documented for a short-term exacerbation. Multiple medications were prescribed together without adequate trials of each. Documentation from the retrospective date of treatment were not included for review. The request does not include frequency or dosing. Per the CA MTUS, Norflex is not indicated and is not medically necessary.

**Retro (DOS 10/10/12, 1/16/13, 2/27/13) Nabumetone 750mg #100: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steroidal anti-inflammatory drugs).

**Decision rationale:** According to CA MTUS chronic pain guidelines, non-steroidal anti-inflammatory agents are recommended as an option for short term symptomatic relief for the treatment of chronic low back pain. Further recommendations are for the lowest dose for a minimal duration of time. Specific recommendations for nambutone is for the treatment of osteoarthritis. The IW does not have a diagnosis of osteoarthritis. The documentation does not support improvement of symptoms with NSAIDs prescribed. Documentation from the retrospective date of treatment were not included for review. The request does not include frequency or dosing. The request for Nambutone is medically not necessary.

**Retro (DOS 1/16/13, 3/27/13) Setraline Hydrochloride 50mg #30: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): SSRIs (selective serotonin reuptake inhibitors).

**Decision rationale:** Sertraline hydrochloride is a selective serotonin reuptake inhibitor (SSRI). According to MTUS guidelines, SSRIs are not recommended for the treatment of chronic pain. They do have a role treating secondary depression. The included records do not include the diagnosis for which this medication is being prescribed. The IW does not have a diagnosis of depression. Documentation from the retrospective date of treatment were not included for review. The request does not include frequency or dosing. The record does not support this medication is being prescribed in accordance with MTUS guidelines. Without this, the request for sertraline is determined not medically necessary.

**Retro (DOS 02/27/13): Hydrocodone 10/325mg #30: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use, Opioids, specific drug list.

**Decision rationale:** CA MTUS, chronic pain guidelines, offer very specific guidelines for the ongoing use of narcotic pain medication to treat chronic pain. These recommendations state that the lowest possible dose be used as well as "ongoing review and documentation of pain relief, functional status, appropriate medication use and its side effects." It also recommends that providers of opiate medication document the injured worker's response to pain medication including the duration of symptomatic relief, functional improvements, and the level of pain relief with the medications. The included documentation fails to include the above recommended documentation. The IW has been prescribed this medication on an ongoing basis. The records submitted do not support improvement of symptoms or function with the use of this medication. Documentation from the retrospective date of treatment were not included for

review. Additionally, the request does not include dosing or frequency. Without this documentation, the request for hydrocodone is not medically necessary in accordance with MTUS guidelines.

**Retro (DOS 1/16/13): Wrist Support: 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), Forearm, Wrist & Hand Chapter, Hand Immobilization.

**MAXIMUS guideline:** Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004, Section(s): Physical Methods, Initial Care. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, wrist and hand: splints.

**Decision rationale:** Ca MTUS ACOEM 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." The IW does not have a documented exam or neuroelectric testing to support a diagnosis of carpal tunnel syndrome. According to the ODG reference, "Recommended for treating displaced fractures. Immobilization is standard for fracture healing although patient satisfaction is higher with splinting rather than casting. Treating fractures of the distal radius with casting versus splinting has no clinical difference in outcome. See also Casting versus splints. Mallet finger: treatment commonly involves splinting of the finger for six or more weeks. Splints used for prolonged immobilization should be robust enough for everyday use, and of the central importance of patient adherence to instructions for splint use. (Handoll-Cochrane, 2004) For rheumatoid arthritis, there was generally a positive effect of splint use on hand function; however, perceived splint benefit was marginal. For most tasks splint use improved or did not change pain levels, did not interfere with work performance, increased or maintained endurance, and did not increase perceived task difficulty. The findings suggest that wrist splint prescription is not a simple process; clinicians and clients need to work together to determine the daily wear pattern that maximizes benefit and minimizes inconvenience according to the client's individual needs. (Pagnotta, 2005) See also Mallet finger (splinting) Following tendon repair: Recovery of finger function after primary extensor tendon repair depends on the complexity of trauma and the anatomical zone of tendon injury. Static splinting is an appropriate tool after primary extensor tendon repair in Verdan's zone 1, 2, 4 and 5, whereas injuries in zones 3 and 6 may demand for a different treatment regimen. (Carl, 2007) Arthritis: A recent randomized controlled study concluded that prefabricated wrist working splints are highly effective in reducing wrist pain after 4 weeks of splint wearing in patients with wrist arthritis. (Veehof, 2008) Hand splints can ease arthritis pain, according to a new systematic review. Short and rigid day splints cut hand pain in half after six months of use, according to one high-quality study. Another study found that hand pain was also cut in half by wearing a long rigid splint every night for a year, but the splints usually didn't improve hand function or strength. The findings mean that splints have about the same effect on pain as ibuprofen, the most common drug in osteoarthritis. A small splint for pain relief during the day combined with a custom-made and rigid splint for prevention of deformities at night may be an optimal regimen." The submitted documentation does provide documentation or explanation for the requested wrist splint. Documentation from the retrospective date of treatment were not included for review. It is unclear from the documentation the duration the splint is intended to be used. The request does not include frequency or dosing. Without the support of the documentation, the request for a wrist splint is determined not medically necessary.