

Case Number:	CM13-0014841		
Date Assigned:	03/10/2014	Date of Injury:	04/23/2013
Decision Date:	08/08/2014	UR Denial Date:	08/12/2013
Priority:	Standard	Application Received:	08/21/2013

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 Preventative Medicine, has a subspecialty in Occupational Medicine and is licensed to practice in Iowa. 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:

This patient is a 26 year old employee with date of injury of 4/23/2013. Medical records indicate the patient is undergoing treatment for right wrist sprain/strain/contusion. Subjective complaints include pain with tingling at right little finger; pain worsens after a day's work; sometimes pain radiates to elbow. Objective findings include right wrist tender to palpation over ulnar side; negative Tinel and Phalen's test; right hand tender to palpation over ulnar aspect with slight pain radiating to 5th finger; full flexion, fingertips to palmar surface; full extension to zero degrees. Treatment has consisted of Tylenol; hand/wrist brace; ice packs; Ibuprofen; physical therapy, an MRI of the right wrist; NCV/EMG of the upper extremity; compound -Capsaicin 0.025% Flurbiprofen 30%/Methyl Salicylate 4% 240gm; Flurbiprofen 20%/ Tramadol 20% 240gm; right wrist x-ray, and chiropractic treatment. The utilization review determination was rendered on 8/12/2013 recommending non-certification of an MRI of the right wrist; EMG/NCV of the right upper extremity; right wrist x-ray; functional capacity evaluation; physical therapy; rental of a TENS unit; topical compound Capsaicin 0.025% Flurbiprofen 30%/Methyl Salicylate 4% 240gm; Flurbiprofen 20%/ Tramadol 20% 240gm; right wrist brace, and chiropractic treatments.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI RIGHT WRIST: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 268-269.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 268-272. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, wrist and Hand, Magnetic Resonance Imaging.

Decision rationale: ACOEM guidelines states that 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 ODG states that for a wrist MRI, indications for imaging include the following:-Acute hand or wrist trauma, suspect acute distal radius fracture, radiographs normal, next procedure if immediate confirmation or exclusion of fracture is required-Acute hand or wrist trauma, suspect acute scaphoid fracture, radiographs normal, next procedure if immediate confirmation or exclusion of fracture is required-Acute hand or wrist trauma, suspect gamekeeper injury (thumb MCP ulnar collateral ligament injury)-Chronic wrist pain, plain films normal, suspect soft tissue tumor-Chronic wrist pain, plain film normal or equivocal, suspect Kienbck's disease-Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. In this case, the treating physician has provided no evidence of red flag diagnosis and has not met the above ODG and ACOEM criteria for an MRI of the wrist. Therefore, the request for an MRI of the right wrist is not medically necessary.

AN EMG OF THE RIGHT UPPER EXTREMITY: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 260-262. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Electrodiagnostic testing (EMG/NCS).

Decision rationale: ACOEM guidelines state that appropriate electrodiagnostic studies (EDS) may help differentiate between CTS and other conditions, such as cervical radiculopathy. These may include nerve conduction studies (NCS), or in more difficult cases, electromyography(EMG) may be helpful. ODG states Recommended needle EMG or NCS, depending on indications. Surface EMG is not recommended. Electromyography (EMG) and Nerve Conduction Studies (NCS) are generally accepted, well-established and widely used for localizing the source of the neurological symptoms and establishing the diagnosis of focal nerve entrapments, such as carpal tunnel syndrome or radiculopathy, which may contribute to or coexist with CRPS II (causalgia), when testing is performed by appropriately trained neurologists or physical medicine and rehabilitation physicians (improperly performed testing by other providers often gives inconclusive results). As CRPS II occurs after partial injury to a nerve, the diagnosis of the initial nerve injury can be made by electrodiagnostic studies. The treating physician does not document evidence of radiculopathy, muscle atrophy, and abnormal neurologic findings. The treating physician does document a negative Tinel's sign. The treating physician has not met the above ACOEM and ODG criteria for an EMG of the upper extremities. Therefore, the request for an EMG of the bilateral upper extremities is not medically necessary.

NCV RIGHT UPPER EXTREMITY: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 260-262. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Electrodiagnostic testing (EMG/NCS).

Decision rationale: ACOEM guidelines state that appropriate electrodiagnostic studies (EDS) may help differentiate between CTS and other conditions, such as cervical radiculopathy. These may include nerve conduction studies (NCS), or in more difficult cases, electromyography (EMG) may be helpful. ODG states Recommended needle EMG or NCS, depending on indications. Surface EMG is not recommended. Electromyography (EMG) and Nerve Conduction Studies (NCS) are generally accepted, well-established and widely used for localizing the source of the neurological symptoms and establishing the diagnosis of focal nerve entrapments, such as carpal tunnel syndrome or radiculopathy, which may contribute to or coexist with CRPS II (causalgia), when testing is performed by appropriately trained neurologists or physical medicine and rehabilitation physicians (improperly performed testing by other providers often gives inconclusive results). As CRPS II occurs after partial injury to a nerve, the diagnosis of the initial nerve injury can be made by electrodiagnostic studies. The treating physician does not document evidence of radiculopathy, muscle atrophy, and abnormal neurologic findings. The treating physician does document a negative Tinel's sign. Therefore, the request for an NCV of the right upper extremity is not medically necessary.

FUNCTIONAL CAPACITY EVALUATION: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation Page(s): 21-42, Chronic Pain Treatment Guidelines Page(s): 125. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Fitness for Duty, Functional capacity evaluation (FCE).

Decision rationale: The CA MTUS guidelines provide specific guidance when an FCE should be done. The CA MTUS guidelines state that the worker must be no more than 2 years past date of injury. Workers that have not returned to work by two years post injury may not benefit. It is two years past the date of injury. ACOEM guidelines state to consider using a functional capacity evaluation when necessary to translate medical impairment into functional limitations and determine work capability. Additionally, it may be necessary to obtain a more precise delineation of patient capabilities than is available from routine physical examination. Under some circumstances, this can best be done by ordering a functional capacity evaluation of the patient. ODG states to consider an FCE if the case management is hampered by complex issues such as prior unsuccessful RTW attempts, conflicting medical reporting on precautions and/or fitness for modified job, injuries that require detailed exploration of a worker's abilities. ODG further states that timing is appropriate. The medical documents provided does not indicate that any of the above criteria were met. The patient is still undergoing treatment and is not noted to

be at MMI or close to MMI. In addition, the treating physician has not detailed the vocational plan and a job description. Therefore, a functional capacity evaluation is not medically necessary.

TWELVE PHYSICAL THERAPY SESSIONS: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 265-266, Chronic Pain Treatment Guidelines PHYSICAL THERAPY, PHYSICAL MEDICINE Page(s): 98-99.

Decision rationale: The MTUS guidelines refer to physical medicine guidelines for physical therapy and allows for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home physical medicine. Additionally, ACOEM guidelines advise against passive modalities by a therapist unless exercises are to be carried out at home by the patient. The ODG recommends PT/OT for sprains and strains of the wrist and hand with 9 visits over 8 weeks. The treating physician does not document the number of previous PT visits and the outcomes of the visits. In addition, the treating physician has not documented a home exercise program. The treating physician has not provided medical documentation to meet the above guidelines for physical therapy visits. Therefore, the request for twelve physical therapy is not medically necessary.

RENTAL TENS UNIT (IN MONTHS) QTY 12: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation, Transcutaneous electrotherapy Page(s): 54, 114-116, 118-120.

Decision rationale: The Chronic Pain Medical Treatment Guidelines state that a TENS unit is not recommended as an isolated intervention. The criteria further note that coverage criteria include documentation of pain ineffectively controlled due to diminished effectiveness of medications; or pain is ineffectively controlled with medications due to side effects; or a history of substance abuse; or - significant pain from postoperative conditions limits the ability to perform exercise programs/ physical therapy treatment; or unresponsive to conservative measures (e.g., repositioning, heat/ice, etc.). If those criteria are met, then a one-month trial maybe appropriate to permit the physician and physical medicine provider to study the effects and benefits. The treating physician does not indicate that the patient has poorly controlled pain, concerns for substance abuse, pain from postoperative conditions that limit ability to participate in exercise programs/treatments, or is unresponsive to conservative measures. Therefore, the request for a twelve month rental of a TENs unit is not medically necessary.

COMPOUND -CAPSAICIN 0.025% FLURBIPROFEN 30%/METHYL SALICYLATE 4% 240GM: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Flurbiprofen, Topical Analgesics Page(s): 28-29, 72, 111-113.

Decision rationale: The Chronic Pain Medical Treatment Guidelines indicate that topical medications are largely experimental in use with few randomized controlled trials to determine efficacy or safety. While topical non-steroidal anti-inflammatory agents (NSAIDs) may be useful for chronic musculoskeletal pain, there are no long-term studies of their effectiveness or safety. The guidelines indicate that topical capsaicin is only recommended as an option in patients who have not responded or are intolerant to other treatments. In this case, the medical records provided do not endorse failure of trials of oral adjuvant analgesics such as antidepressants or anticonvulsants. The guidelines recommend FDA-approved agents: Voltaren Gel 1% (diclofenac): Indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist) and the request is for 30% flurbiprofen which exceeds the FDA approved amount for Diclofenac 1% (an NSAID). There is no support from the guidelines to exceed the FDA guidelines of 1%. In addition, the guidelines further state that, any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Therefore, the request for the topical compound Capsaicin 0.025% Flurbiprofen 30%/Methyl Salicylate 4% 240gm is not medically necessary.

FLURBIPROFEN 20%/ TRAMADOL 20% 240GM: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Flurbiprofen, Topical Analgesics Page(s): 72, 93-94, 111-113.

Decision rationale: The Chronic Pain Medical Treatment Guidelines state that topical medications are largely experimental in use with few randomized controlled trials to determine efficacy or safety. These are primarily recommended for neuropathic pain when trials of antidepressants and anti-convulsants have failed. In this case, the medical records provided do not endorse failure of trials of oral adjuvant analgesics such as antidepressants or anticonvulsants. It is also noted this particular formulation contains agents that are not recommended for topical use under guidelines, specifically Tramadol. MTUS guidelines also state that any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Therefore, the request for Flurbiprofen 20%/ Tramadol 20% 240gm is not medically necessary.

RIGHT WRIST X-RAY: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 268-272. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, wrist and Hand, Magnetic Resonance Imaging.

Decision rationale: ACOEM guidelines do not recommend the use of an x-ray for routine wrist conditions. The ODG states the indications for x-rays include the following: -Acute hand or wrist trauma, wrist trauma, first exam-Acute hand or wrist trauma, suspect acute scaphoid fracture, first exam, plus cast and repeat radiographs in 10-14 days -Acute hand or wrist trauma, suspect distal radioulnar joint subluxation-Acute hand or wrist trauma, suspect hook of the hamate fracture-Acute hand or wrist trauma, suspect metacarpal fracture or dislocation-Acute hand or wrist trauma, suspect phalangeal fracture or dislocation-Acute hand or wrist trauma, suspect thumb fracture or dislocation-Acute hand or wrist trauma, suspect gamekeeper injury (thumb MCP ulnar collateral ligament injury)-Chronic wrist pain, first study obtained in patient with chronic wrist pain with or without prior injury, no specific area of pain specified. In this case, the medical documents indicate that a previous wrist x-ray was negative, the treating physician has not provided a clear rationale as to why another x-ray is needed at this time. The treating physician does not provide documentation to meet the above criteria. Therefore, the request for a right wrist x-ray is not medically necessary.

RIGHT WRIST BRACE: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 268-272. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, wrist and Hand, Magnetic Resonance Imaging.

Decision rationale: The ACOEM guidelines state that splinting is first-line conservative treatment for CTS, DeQuervain's, strains and notes that Prolonged splinting leads to weakness and stiffness. ODG states that statistical evaluation identified five factors, which were important in predicting lack of response to wrist splints: (1) age over 50 years, (2) duration over ten months, (3) constant paraesthesiae, (4) stenosing flexor tenosynovitis, and (5) a Phalen's test positive in less than 30 seconds. When none of these factors was present, 66% of patients were cured by medical therapy, 40% of patients with one factor, 17% with two factors, and 7% with three factors, and no patient with four or five factors present was cured by medical management. Data suggest that splinting is most effective if applied within three months of symptom onset. This systematic review found that the usefulness of splinting as initial treatment for improving CTS symptoms is still supported by recent literature, but these effects are temporary. While the treating physician does document a positive Tinel's sign, the treating physician does not explain why a right wrist brace is needed after an initial trial and failure. Therefore, the request for a right wrist brace is not medically necessary.

SIX CHIROPRACTIC TREATMENTS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MANUAL THERAPY AND MANIPULATION Page(s): 58-59.

Decision rationale: The Chronic Pain Medical Treatment Guidelines state that manual therapy is widely used in the treatment of musculoskeletal pain. The intended goal or effect of manual medicine is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. Manipulation is manual therapy that moves a joint beyond the physiologic range-of-motion but not beyond the anatomic range-of-motion. The guidelines do not recommend manual therapy for forearm, wrist, hand, and knee. The request includes manual therapy for the wrist. Therefore, the request for six chiropractic treatments is not medically necessary.