

Case Number:	CM13-0019638		
Date Assigned:	11/27/2013	Date of Injury:	09/30/2008
Decision Date:	06/24/2014	UR Denial Date:	08/05/2013
Priority:	Standard	Application Received:	09/03/2013

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 Physical Medicine and Rehabilitation, has a subspecialty in Pain Management, 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:

This patient is a 45-year-old female with date of injury September 30, 2008. Per treating physician's report which is handwritten, dated September 16, 2013, the listed diagnoses: status post right carpal tunnel release, status post left carpal tunnel release, right carpal tunnel syndrome residual, low back pain, C-spine pain, bilateral shoulder pain. Request was for postoperative left wrist strengthening program two times a week for three weeks and also acupuncture two times a week for three weeks. There is an operative report dated May 2, 2013 for left carpal tunnel release. The request for postoperative therapy and acupuncture treatments were denied by utilization review letter August 5, 2013 with the rationale that the guidelines only allow three to five sessions of postoperative therapy and that functional improvement from prior acupuncture treatments were not documented.

IMR ISSUES, DECISIONS AND RATIONALES

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

Postoperative acupuncture for the left wrist (6 sessions): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: Acupuncture Medical Treatment Guidelines, ,

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CHRONIC PAIN MEDICAL TREATMENT GUIDELINES MTUS 9792.2(F) "FUNCTIONAL IMPROVEMENT" MEANS EITHER A.

Decision rationale: This patient is status post left carpal tunnel release from May 2, 2013. The request is for acupuncture, six sessions. Review of July 16, 2013 report indicates that the patient had acupuncture following surgery. However, there is no discussion regarding functional improvement. Functional improvement is defined in Labor Code 9792.20 by significant improvement in ADL (activities of daily living), or change in work status and less dependence on medical treatments. These documentations are not provided following previous acupuncture treatments. In addition, the acupuncture treatments are not indicated. The request for Postoperative acupuncture for the left wrist, six sessions, is not medically necessary or appropriate.

Postoperative physical therapy for the left wrist (6 sessions): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: Chronic Pain Medical Treatment Guidelines, ,

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CHRONIC PAIN MEDICAL TREATMENT GUIDELINES CARPAL TUNNEL SYNDROME (PG 15, MTUS POST-SURGICAL GUID.

Decision rationale: This patient is status left carpal tunnel release from May 2, 2013. The July 16, 2013 report requested additional postoperative physical therapy for 2 times a week for 3 weeks, indicating that patient's current therapy treatments have been helpful. The Chronic Pain Medical Treatment Guidelines for postoperative care following carpal tunnel release recommend only three to five sessions of physical therapy. Review of the reports show that the patient has had a number of therapy visitations following left carpal tunnel release. There are multiple therapy reports through May and June. It would appear that the patient has had adequate postoperative therapy, and additional 6 sessions requested physical therapy is not supported by the guidelines. The request for Postoperative physical therapy for the left wrist, six sessions, is not medically necessary or appropriate.

A solar care FIR heating system: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) NOT RECOMMENDED OVER OTHER HEAT THERAPIES. WHERE DEEP HEATING IS DESIRABLE, PROVIDERS MAY CONSIDER A LIMITED TRIAL OF IR THERAPY FOR TREATMENT OF ACUTE LBP, BUT ONLY IF USED AS AN ADJUNCT TO A PROGRAM OF EVIDENCE-BASED CONSERVATIVE CARE (EXERCISE). THE IR

THERAPY UNIT USED IN THIS TRIAL WAS DEMONSTRATED TO BE EFFECTIVE IN REDUCING CHRONIC LOW BACK PAIN, AND NO ADVERSE EFFECTS WERE OBSERVED; THE IR GROUP EXPERIENCED A 50% PA

Decision rationale: This patient presents with chronic bilateral upper extremity pains, and the patient is status post left carpal tunnel release from May 2, 2013. The request is for FIR heating system which is an infrared heating system. ODG guidelines states under infrared therapy, "not recommended over other heat therapies. Where deep heating is desirable, provider may reconsider a limited trial of IR therapy for treatment of acute low back pain, but only if used as an adjunct to a program of evidenced-based conservative care." Given the lack of support for routine use of infrared therapy at home, the request cannot be supported. ACOEM and ODG guidelines further state that at home, local application of heat/cold should be adequate for management of pain. In this case, home use of infrared therapy is not supported by ODG guidelines. The request for A solar care FIR heating system is not medically necessary or appropriate.

The compounded topical gabapentin/ketoprofen/lidocaine/Ultra cream: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: Chronic Pain Medical Treatment Guidelines, ,

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CHRONIC PAIN MEDICAL TREATMENT GUIDELINES THE MTUS HAS THE FOLLOWING REGARDING TOPICAL CREAMS(P1.

Decision rationale: This patient presents with chronic upper extremity pain and the patient is status post left carpal tunnel release from May 2, 2013. The treating physician has asked for compounded cream that includes ketoprofen, gabapentin, lidocaine, and Ultram. The Chronic Pain Medical Treatment Guidelines provides specific discussion regarding compounded topical products. If one of the components is not recommended, then the entire compounded product is not recommended. In this case, ketoprofen is not recommended, gabapentin is not recommended, and Ultram is not supported by the Chronic Pain Medical Treatment Guidelines for topical formulation. The request for compounded topical gabapentin/ketoprofen/lidocaine/Ultra cream is not medically necessary or appropriate.

Vicodin ES #60 with one refill: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: Chronic Pain Medical Treatment Guidelines, ,

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CHRONIC PAIN MEDICAL TREATMENT GUIDELINES MTUS PG 76-80 CRITERIA FOR USE OF OPIOIDS Page(s): 76-.

Decision rationale: This patient presents with chronic upper extremity pains and the patient is status post left carpal tunnel release from May 2, 2013. There is a request for Vicodin Extra-Strength sixty count with one refill. Chronic Pain Medical Treatment Guidelines do support use of opiates for musculoskeletal pain and particularly for postoperative pain for short term. The patient is status post left carpal tunnel release from May 2, 2013 and the prescription for Vicodin Extra-Strength #60 with 1 refill appears medically reasonable to try. However, for long term use or chronic use of Vicodin, documentation on pain and function, 4As including analgesia, activities of daily living, adverse effects, adverse drug seeking behavior must be documented According to the Chronic Pain Medical Treatment Guidelines. Given the patient's postoperative period, Vicodin #60 with 1 refill appear medically reasonable. The request for Vicodin ES, sixty count with one refill, is medically necessary and appropriate.