

<b>Case Number:</b>	CM13-0028386		
<b>Date Assigned:</b>	11/27/2013	<b>Date of Injury:</b>	05/21/2012
<b>Decision Date:</b>	07/24/2014	<b>UR Denial Date:</b>	08/30/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/24/2013

### 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 and is licensed to practice in Illinois. 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:

The injured worker is a 42-year-old female with a reported date of injury on 05/21/2012. The mechanism of injury reportedly occurred from repetitive use. The injured worker complained of pain in her neck and bilateral upper extremities. Upon physical examination, the injured worker presented with less than full range of motion in the right wrist and upper extremity, and positive Tinel's at the volar wrist. The physical examination of the left hand, and upper extremity showed positive Tinel's at the medial elbow. The clinical documentation indicated that the injured worker previously participated in physical therapy; the results of which were provided within the documentation available for review. The MRI of the right thumb dated 05/02/2013, revealed evidence of injury to the joint capsule and the possibility of a fracture. The injured worker's diagnosis included right carpal tunnel syndrome, left mild carpal tunnel syndrome, left cubital tunnel syndrome, cervical degenerative disc disease, and right thumb sprain. The injured worker's medication regimen was not provided within the documentation available for review. The request for authorization for acupuncture therapy and treatment to the cervical spine two (2) times per week for four (4) weeks for a total of eight (8) sessions, one (1) transdermal medication, and follow-up on 09/26/2013 was submitted on 09/04/2013. The physician indicated that the goal of acupuncture was to reduce the need for non-steroidal anti-inflammatory drugs (NSAIDs) and opioid medication use and increase the injured worker's functional capacity, increase activities of daily living, and maximize the injured worker's treatment outcome.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Acupuncture therapy treatment to the cervical spine, two (2) times per week for four (4) weeks:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**Decision rationale:** The Acupuncture Medical Treatment Guidelines recommend acupuncture as an option when pain medication is reduced or not tolerated; it may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. The Guidelines also recommend functional improvement of three to six (3 to 6) treatments with a frequency of one to three (1 to 3) times per week and an optimum duration of one to two (1 to 2) months. Acupuncture treatments may be extended if functional improvement is documented. The clinical information provided for review lacks documentation related to the injured worker's medication regimen. There was a lack of documentation related to the injured worker's pain medication being reduced or not tolerated. In addition, there was a lack of documentation related to the use of physical therapy in adjunct to acupuncture treatments. Furthermore, the guidelines state the time to produce functional improvement is three to six (3 to 6) treatments. The request for eight (8) sessions exceeds the recommended guidelines. Therefore, the request for acupuncture therapy treatment to the cervical spine, two (2) times per week for four (4) weeks is not medically necessary.

**One (1) transdermal medication:** 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 Topical Analgesics Page(s): 111.

**Decision rationale:** The Chronic Pain Guidelines recommend topical analgesics as an option. Although largely experimental in use with few randomized controlled trials to determine effectiveness or safety. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is a lack of documentation related to the injured worker's functional deficits. The clinical information provided lacks documentation related to the injured worker's medication regimen. In addition, the request as submitted failed to provide the specific transdermal medication, dosage, frequency, directions for use, and specific site at which the transdermal patch was to be utilized. Therefore, the request for one (1) transdermal medication is not medically necessary.

**One (1) follow-up on 09/26/2013:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), Occupational Medicine Practice Guidelines, Evaluation and

Management of Common health Problems and Functional Recovery in Workers, 2nd Edition, 2004.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Office Visit.

**Decision rationale:** The Official Disability Guidelines recommend office visits as determined to be medically necessary. The evaluation and management of outpatient visits to the offices of medical doctors plays a critical role in the proper diagnosis and return to function of an injured worker and they should be encouraged. The need for a clinical office visit with a healthcare provider is individualized based upon a review of the patient's concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The determination of necessity for an office visit requires individualized case review and assessment, being ever mindful that the best patient outcomes are achieved with eventual patient independence from the healthcare system through self care as soon as clinically feasible. The clinical information provided for review lacks documentation of an injured worker's functional deficits to include range of motion values. The injured worker's medication regimen was not included within the documentation available for review. In addition, the request as submitted failed to provide the specific goal as it relates to the follow up visit. Therefore, the request for follow-up on 09/26/2013 is not medically necessary.