

Case Number:	CM13-0046725		
Date Assigned:	12/27/2013	Date of Injury:	06/18/2008
Decision Date:	04/22/2014	UR Denial Date:	10/22/2013
Priority:	Standard	Application Received:	11/01/2013

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 Emergency Medicine, and is licensed to practice in New York. 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 patient is a 40-year-old female who was injured on June 18, 2008. The patient continued to experience pain in her neck, left elbow, and bilateral wrists. The medical record from October 1, 2013 states that there has been no change in the patient's condition, hat home exercise plan has failed, and that medications have been increased. The remainder of the medical record is illegible. Diagnoses included cervical spine pain, bilateral carpal tunnel syndrome, and left elbow pain. Requests for authorization for twelve sessions of acupuncture for the cervical spine, left elbow, and bilateral wrists, purchase of solar care far infrared heating system, Toprophan # 60 with one refill, and Naproxen cream 260 gm with one refill were submitted for consideration.

IMR ISSUES, DECISIONS AND RATIONALES

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

12 SESSIONS OF ACUPUNCTURE FOR THE CERVICAL SPINE, LEFT ELBOW AND BILATERAL WRISTS: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: Section 9792.24.1 of the California Code of regulations states that Acupuncture is used as an option when pain medication is reduced or not tolerated or as an

adjunct to physical rehabilitation. It is the insertion and removal of filiform needles to stimulate acupoints (acupuncture points). Needles may be inserted, manipulated, and retained for a period of time. Acupuncture can be used to reduce pain, reduce inflammation, increase blood flow, increase range of motion, decrease the side effect of medication-induced nausea, promote relaxation in an anxious patient, and reduce muscle spasm. Acupuncture with electrical stimulation is the use of electrical current on the needles at the acupuncture site. It is used to increase effectiveness of the needles by continuous stimulation of the acupoint. Physiological effects (depending on location and settings) can include endorphin release for pain relief, reduction of inflammation, increased blood circulation, analgesia through interruption of pain stimulus, and muscle relaxation. It is indicated to treat chronic pain conditions, radiating pain along a nerve pathway, muscle spasm, inflammation, scar tissue pain, and pain located in multiple sites. Specific indications for treatment of pain include treatment of joint pain, joint stiffness, soft tissue pain and inflammation, paresthesias, post-surgical pain relief, muscle spasm and scar tissue pain. Official Disability Guidelines (ODG) states that acupuncture is not recommended for acute back pain, but is recommended as an option for chronic low back pain in conjunction with other active interventions. Acupuncture is recommended when use as an adjunct to active rehabilitation. Frequency and duration of acupuncture or acupuncture with electrical stimulation may be performed as follows: 1) Time to produce functional improvement: 3 to 6 treatments. 2) Frequency: 1 to 3 times per week. 3) Optimum duration: 1 to 2 months. Acupuncture treatments may be extended if functional improvement is documented. In this case the request is for 12 sessions. There should be evidence of functional improvement after 3-6 treatments. If no functional improvement has occurred after 6 treatments, then they should not be continued. The request for 12 treatments surpasses the recommended 3-6 treatments to determine efficacy. The request should not be authorized.

PURCHASE OF ONE (1) SOLAR CARE FAR INFRARED (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 8 Neck and Upper Back Complaints Page(s): 174.

Decision rationale: Heat/cold applications are recommended. Insufficient testing exists to determine the effectiveness (if any) of heat/cold applications in treating mechanical neck disorders, though due to the relative ease and lack of adverse effects, local applications of cold packs may be applied during first few days of symptoms followed by applications of heat packs to suit patient. California Medical Treatment Utilization Schedule (MTUS) does not comment on infrared heating systems to apply heat. The lack of evidence does not allow determination of efficacy or safety.

#60 TOPROPHAN WITH ONE (1) REFILL: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation A NON-CALIFORNIA MEDICAL TREATMENT UTILIZATION SCHEDULE (MTUS) CITATION.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) PAIN, MEDICAL FOOD, MELATONIN VITAMIN B.

Decision rationale: California Medical Treatment Utilization Schedule (MTUS) does not address this topic. Tropicamide is a compounded medical nutritional supplement containing vitamin B-6, L-tryptophan, chamomile, valerian extract, melatonin, inositol, and other ingredients. Per the [REDACTED] website, it may aid the patient in falling and staying asleep. The guidelines state that "Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." Vitamin B is not recommended. Vitamin B is frequently used for treating peripheral neuropathy but its efficacy is not clear. Melatonin is recommended for the treatment of insomnia. In published studies melatonin shows potent analgesic effects in a dose-dependent manner, and melatonin has been shown to have analgesic benefits in patients with chronic pain. Also, the repeated administration of melatonin improves sleep and thereby may reduce anxiety, which leads to lower levels of pain. There is no comment on L-tryptophan, chamomile, valerian extract, or inositol. The lack of evidence does not allow determination of efficacy or safety. This nutritional supplement contains ingredients that are not recommended. Therefore, it is not recommended.

#2 NAPROXEN CREAM 240GM WITH ONE (1) REFILL: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation NON-MTUS

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines PAIN INTERVENTIONS AND TREATMENTS Page(s): 111-112.

Decision rationale: Naproxen is a non-steroidal anti-inflammatory drug (NSAID). Topical non-steroidal anti-inflammatory drugs (NSAIDs) have been shown to be superior to placebo in the treatment of osteoarthritis, but only in the short term and not for extended treatment. The effect appears to diminish over time. Absorption of the medication can occur and may have systemic side effects comparable to oral form. Adverse effects for GI toxicity and renal function have been reported. It has not been evaluated for treatment of the spine, hip, or shoulder. Diclofenac gel is the only FDA approved (NSAID). Naproxen is recommended as an oral medication for osteoarthritis or ankylosing spondylitis. It is not recommended as a topical preparation. The request should not be authorized.