

Case Number:	CM13-0065537		
Date Assigned:	01/03/2014	Date of Injury:	11/03/2011
Decision Date:	05/16/2014	UR Denial Date:	11/27/2013
Priority:	Standard	Application Received:	12/13/2013

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 Pain Medicine and is licensed to practice in Texas and Ohio. 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 56-year-old female who reported an injury on 11/03/2011. Due to cumulative trauma while performing normal job duties. The injured worker developed bilateral wrist and forearm complaints. The injured worker's treatment history included right carpal tunnel release, right distal forearm fasciotomy, postoperative occupational therapy, immobilization, and multiple medications. The injured worker was evaluated on 09/03/2013. It was documented that the injured worker had persistent right-handed carpal tunnel syndrome. Physical findings included decreased grip strength of the right hand, 5-/5 of the right upper extremity with a right-sided reverse Phalen's test and carpal tunnel tenderness along the left and right side. The injured worker's diagnoses included bilateral carpal tunnel syndrome, status post carpal tunnel release persistent symptomatology. The injured worker's treatment recommendations included an EMG/NCV of the bilateral upper extremities, an MRI of the right wrist due to persistent symptomatology of the carpal tunnel syndrome status post surgical intervention, multiple medications, and corticosteroid injections to the bilateral carpal tunnel areas for diagnostic and treatment purposes.

IMR ISSUES, DECISIONS AND RATIONALES

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

CORTISONE STEROID INJECTION TO THE LEFT CARPAL TUNNEL AREA:

Overtuned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 265.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 271.

Decision rationale: The requested corticosteroid injection to the left carpal tunnel area is medically necessary and appropriate. The American College of Occupational and Environmental Medicine recommends corticosteroid injections for injured workers that have symptomatology consistent with carpal tunnel syndrome. The injured worker has had ongoing treatment to include surgical intervention for carpal tunnel syndrome and has remained symptomatic; however, it is noted in the clinical documentation that the patient has never undergone corticosteroid injections. As this is a conservative treatment that has not been attempted for this patient to provide pain relief, it would be supported. As such, the requested corticosteroid injection into the left carpal tunnel area is medically necessary and appropriate.

CORTISONE STEROID INJECTION TO THE RIGHT CARPAL TUNNEL AREA:
Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 265.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 271.

Decision rationale: The requested corticosteroid injection to the left carpal tunnel area is medically necessary and appropriate. The American College of Occupational and Environmental Medicine recommends corticosteroid injections for injured workers that have symptomatology consistent with carpal tunnel syndrome. The injured worker has had ongoing treatment to include surgical intervention for carpal tunnel syndrome and has remained symptomatic; however, it is noted in the clinical documentation that the patient has never undergone corticosteroid injections. As this is a conservative treatment that has not been attempted for this patient to provide pain relief, it would be supported. As such, the requested corticosteroid injection into the left carpal tunnel area is medically necessary and appropriate.

A HOT/COLD WRAP: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 265-266.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 271-273.

Decision rationale: The requested hot/cold wrap is not medically necessary or appropriate. The American College of Occupational and Environmental Medicine recommends hot and cold applications to assist with pain control. However, there is no documentation that the injured

worker is currently participating in any type of active therapy that would benefit from an adjunct passive therapy. Additionally, there is no evidence that the injured worker has failed to respond to self managed, self-directed hot and cold applications. Therefore, there is no justification for a combination hot cold wrap. As such, the requested hot/cold wrap is not medically necessary or appropriate.

NAPROXEN SODIUM 550MG #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 66,73.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications For Chronic Pain Section and the NSAIDs Section.

Decision rationale: The requested naproxen sodium 550 mg is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does support the use of nonsteroidal anti-inflammatory drugs in the management of pain related to carpal tunnel syndrome. However, the request as it is submitted does not provide a frequency of treatment. Therefore, the appropriateness of the request as it is submitted cannot be determined. As such, the request 60 naproxen sodium 550 mg is not medically necessary or appropriate.

PRILOSEC 20MG #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 69.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAID, GI Symptoms & Cardiovascular Risk Section Page(s): 68.

Decision rationale: The requested 60 Prilosec 20 mg is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends gastrointestinal protectants for injured workers who are at risk for developing gastrointestinal events related to medication usage. The clinical documentation submitted for review does not provide an adequate assessment of the injured worker's gastrointestinal system to support that they are at sick risk for developing gastrointestinal events as a result of medication usage. Additionally, the request as it is submitted does not provide a frequency of treatment. Therefore, the appropriateness of the request itself cannot be determined. As such, the requested 60 Prilosec 20 mg is not medically necessary or appropriate.

GABAPENTIN 600MG #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 18-19,49. Decision based on Non-MTUS Citation MTUS: Chronic Pain Medical Treatment Guidelines, , 18-19, 49

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Epileptic Section Page(s): 16. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, ANTI-EPILEPTICS, PAGE 16

Decision rationale: The requested Gabapentin 600 mg is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does recommend the use of anticonvulsants and antiepileptics as first line treatments for neuropathic pain. However, the request as it is submitted does not provide a frequency of treatment. Therefore, the appropriateness of the request cannot be determined. As such, the requested 90 Gabapentin 600 mg is not medically necessary or appropriate.

20 TEROGIN PATCHES: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Section Page(s): 111.

Decision rationale: The requested Terocin patches are not medically necessary or appropriate. The requested medication is a topical analgesic that contains Capsaicin, menthol, and methyl salicylate. The California Medical Treatment Utilization Schedule does recommend the use of menthol and methyl salicylate in the management of osteoarthritic pain. However, the California Medical Treatment Utilization Schedule does not recommended the use of Capsaicin as a topical analgesic unless all forms of first line chronic pain management treatments have been exhausted. The clinical documentation does not provide any evidence that the injured worker has failed to respond to first line medications such as antidepressants and anticonvulsants. Therefore, the use of this medication is not supported. Additionally, the request as it is submitted does not provide a dosage or frequency of treatment. Therefore, the appropriateness of the request itself cannot be determined. As such, the requested 20 Terocin patches are not medically necessary or appropriate.