

Case Number:	CM13-0071982		
Date Assigned:	01/15/2014	Date of Injury:	12/08/2003
Decision Date:	06/19/2014	UR Denial Date:	12/13/2013
Priority:	Standard	Application Received:	12/30/2013

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 & Rehabilitation and is licensed to practice in Texas. 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 sustained an injury on 12/08/03. No specific mechanism of injury was noted. The injured worker was seen by [REDACTED] on 11/14/13 with complaints of pain in the bilateral upper extremities. Medications at this visit included Voltaren 1% gel, Trazodone 50mg, Lyrica 75mg and Flector Patch 1.3%. The note referenced recent injections in October of 2013 that helped reduce overall pain. Previous electrodiagnostic studies from 2010 were unremarkable for findings. On physical examination there was positive Tinel sign at the right wrist. Post-operative changes were noted at the left wrist with positive Tinel and Phalen signs. Mild weakness at the abductor pollicis brevis bilaterally was noted and abductor digiti minimi. Sensation was decreased over the index ring and little fingers bilaterally. The injured worker was recommended for a cryo (cold) stimulation treatment unit with wrist sleep supports for both wrists and use of MediBeads and H-wave unit and palm rest driving aid. The injured worker was also recommended for further acupuncture sessions. Medications were continued at this visit. The requested cryo stimulation unit, cryo gel wrist sleep supports and Lyrica 75mg, quantity 46 were all denied by utilization review dated 12/13/13.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 CRYOSTIM UNIT: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG

Decision rationale: In regards to the requested cryo stim unit, the appeal letter on 12/09/13 indicated that the cryo stim unit provided effective continuous cold therapy at a consistent temperature to address pain and swelling. According to the Official Disability Guidelines, there are indications for the use of cold therapy units following certain surgical procedures in the joints such as the shoulder or knee as well as after a carpal tunnel release. Otherwise, there was no evidence in the clinical literature establishing that the use of a cold therapy unit is any more beneficial than standard (over-the-counter) hot and cold pack therapy for musculoskeletal pain. Therefore, the request is not medically necessary and appropriate.

1 CRYO GEL: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: In regard to the requested cryo gel, the provided appeal letter from 12/09/13 combined the cryo gel in with the requested cryo stim unit. As noted with the cryo stim unit, there is insufficient evidence within the clinical literature establishing that cryo stim and cryo gel therapy for musculoskeletal pain was any more beneficial than standard hot and cold pack therapy. Therefore this request is not medically necessary and appropriate.

2 FUTURO NIGHT WRIST SLEEP SUPPORT #2 (LEFT AND RIGHT HAND):
Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: ACOEM PRACTICE GUIDELINES., CHAPTER 11: FOREARM, WRIST, AND HAND COMPLAINTS, 264,265

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG

Decision rationale: In regard to the requested bilateral night wrist sleep supports, the appeal letter from 12/09/13 recommended the braces to provide protection comfort and support during activities and exercises. As well as prophylactic effect on dynamic impact situations which would have provided greater pain relief. Based on the medical records provided for review, there were persistent positive Tinel and Phalen's signs bilaterally indicative of a persistent carpal bilateral carpal tunnel syndrome. The last electrodiagnostic studies were three years out of date. The injured worker was already noted to have had a prior surgical change consistent with carpal tunnel release. Given the objective evidence consistent with bilateral carpal tunnel syndrome as well as guideline recommendations regarding the use of night splints in the treatment of symptomatic carpal tunnel syndrome, this request is medically necessary and appropriate.

LYRICA 75MG #46: 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., CHAPTER: LYRICA® (PREGABALIN),

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 16-22.

Decision rationale: In regard to the request for Lyrica 75mg quantity 46, the appeal letter from 12/09/13 indicated this medication was prescribed to address fibromyalgia syndrome and could be utilized to address continuing neuropathic pain. This medication request was modified in the previous denial for an allowance of weaning. In review of the medical records provided for review, the injured worker was taking several topical anti-inflammatory medications including Voltaren and Flector Patches. The injured worker was also utilizing Trazodone for sleep. The injured worker reported good benefits from the use of medications. Given the objective findings consistent with a persistent bilateral carpal tunnel syndrome which was supported by the post-operative changes as well as physical examination findings, and as Lyrica was recommended as first line medication in the treatment of neuropathic pain, the request for Lyrica is medically necessary and appropriate.