

Case Number:	CM14-0014565		
Date Assigned:	02/28/2014	Date of Injury:	08/18/2009
Decision Date:	07/08/2014	UR Denial Date:	01/14/2014
Priority:	Standard	Application Received:	02/05/2014

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 Orthopedic Surgery, has a subspecialty in Hand Surgery, 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 42-year-old who reported an injury on August 18, 2009. The mechanism of injury was not provided in the documentation. Per the clinical note dated January 7, 2014, the injured worker reported continuing dull, aching pain rated at a 7/10 to the right wrist and hand, left wrist, right elbow, and right shoulder with loss of sleep due to pain. On physical examination, the cervical spine appeared normal with no paracervical tenderness or myospasm palpable with full range of motion in all planes. Palpation revealed tenderness on the right wrist with decreased range of motion due to wrist pain. Left wrist was positive for Tinel's and Phalen's. The injured worker was reported to have had carpal tunnel release on the right hand on February 27, 2013. The EMG studies of the cervical spine and upper extremities showed no acute or chronic denervation potentials, and the nerve conduction study of the upper extremities did not reveal any electrophysiological evidence of peripheral nerve entrapment. The injured worker's diagnoses included carpal sprain/strain, carpal tunnel syndrome, trigger finger, elbow sprain/strain, and shoulder sprain/strain. Previous treatments for the injured worker were reported to include therapy, previous injections, acupuncture, and physical therapy. The Request for Authorization for Medical Treatment for the wrist injection, Functional Capacity Evaluation, IV sedation, meds, and creams was submitted January 7, 2014. The provider's rationale for the request was not provided within the documentation for the Functional Capacity Evaluation, the meds, or the creams; however, the right wrist injection was reported to be requested for pain, and the IV sedation was requested as the injured worker was apprehensive about the injection.

IMR ISSUES, DECISIONS AND RATIONALES

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

RIGHT WRIST INJECTION UNDER FLUOROSCOPY: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines INJECTIONS.

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

Decision rationale: According to the Forearm, Wrist, and Hand Complaints Chapter of the ACOEM Practice Guidelines, most invasive techniques, such as needle acupuncture and injection procedures, have insufficient high quality evidence to support their use. There is a lack of documentation regarding physical therapy after surgery of the right wrist and the efficacy of that surgery. The documentation provided reported acupuncture treatments; however, there is a lack of clinical data regarding the outcome of those treatments. There is a lack of documentation regarding oral pain medications utilized by the injured worker and the efficacy and side effects associated with those medications. In addition, there is a lack of documentation within the request regarding the type of injection requested. The request for right wrist injection under fluoroscopy is not medically necessary or appropriate.

FUNCTIONAL CAPACITY EVALUATION (QTY: 1.00): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines FUNCTIONAL RESTORATION PROGRAMS (FRPS).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 77.

Decision rationale: According to the Cornerstones of Disability Prevention and Management Chapter of the ACOEM Practice Guidelines, it may be necessary to obtain a more precise delineation of patient capabilities than is available from routine physical examination. Under some circumstances, this can best be done by ordering a functional capacity evaluation of the patient. The Official Disability Guidelines further state, functional capacity evaluations are recommended prior to admission to a work hardening program. Functional capacity evaluations are not recommended if the sole purpose is to determine the injured worker's effort or compliance. There is a lack of documentation regarding the need for the evaluation. The documentation reported the injured worker was already deemed permanent and stationary in 2012. In addition, there is no indication the injured worker plans to participate in a work hardening program that would warrant the use of a functional capacity evaluation. The request for functional capacity evaluation, quantity of one, is not medically necessary or appropriate.

IV SEDATION (UNSPECIFIED) QTY: 1.00: 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 Other Medical Treatment Guideline or Medical Evidence: <http://www.aanw.net/site/patient-information/faqs/iv-sedation-mac-or-monitored-anesthesia-care/>.

Decision rationale: According to the [REDACTED], IV sedation may not be indicated or sufficient for many surgical procedures or specific patient situations. Nausea and vomiting are exceptionally rare following sedation anesthesia, although they do occur sometimes. Sedative medications can impair functional ability for hours after their administration. There is a lack of documentation regarding the need for the sedation. There is a lack of documentation within the request regarding the type of sedation. The injection has been non-certified, thereby making the sedation unnecessary. The request for IV (intravenous) sedation (unspecified), quantity of one, is not medically necessary or appropriate.

MEDS (UNSPECIFIED) QTY: 1.00: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Functional Restoration Approach to Chronic Pain Management Page(s): 7-8.

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines, using medications in the treatment of pain requires a thorough understanding of the mechanism underlying the pain, as well as to identify comorbidities that might predict an adverse outcome. Choice of pharmacotherapy must be based on the type of pain to be treated, and there may be more than 1 pain mechanism involved. The physician should tailor medications and dosages to the individual, taking into consideration patient specific variables such as comorbidities, other medications, and allergies. When effective, medications provide a degree of analgesia that permits the patients to engage in rehabilitation, improvement of activities of daily living, or return to work. There are no drugs that have been proven to reverse, cure, or heal chronic pain. There is a lack of documentation regarding medications utilized by the injured worker currently and the efficacy and side effects of those medications. There is a lack of clinical documentation regarding variables such as comorbidities and allergies for the injured worker. In addition, there is a lack of documentation within the request to indicate the medication requested, including name, dosage, and instructions for use. The request for meds (unspecified), quantity of one, is not medically necessary or appropriate.

CREAMS (UNSPECIFIED) QTY: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL ANALGESICS.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111-113.

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines, topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least one drug or drug class that is not recommended is not recommended. There was a lack of documentation regarding previous topical use and the efficacy of the topical. There was a lack of documentation regarding oral medications used prior to the request for the cream and the efficacy of those medications. There is a lack of clinical documentation regarding variables such as comorbidities and allergies for the injured worker that would prevent the use of oral medications. In addition, there is a lack of documentation within the request regarding the name, dosage, and instructions for the use of the cream. The request for creams (unspecified), quantity of one, is not medically necessary or appropriate.