

<b>Case Number:</b>	CM14-0113696		
<b>Date Assigned:</b>	08/01/2014	<b>Date of Injury:</b>	03/26/1999
<b>Decision Date:</b>	10/08/2014	<b>UR Denial Date:</b>	07/10/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/21/2014

### 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 Internal Medicine, Pulmonary Diseases and is licensed to practice in California. 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 62-year-old female who reported injury on 03/26/1999. Mechanism of injury was not submitted in report for review. The injured worker has diagnoses of spinal discopathy, facet arthropathy, and right lateral epicondylitis. The documentation submitted for review did not indicate any past medical treatment the injured worker has undergone, except for the notations of surgery and medication therapy. Medications include Ambien, Risperdal, Xanax, Omeprazole, Atenolol, and Hydrochlorothiazide. There were no diagnostics submitted for review. On 06/16/2014 the injured worker complained of right shoulder, right hand, and right wrist pain. Physical examination of the right shoulder revealed tenderness to palpation on the sternoclavicular joint, anterior capsule, and acromioclavicular joint. Range of motion revealed an abduction of 80 degrees, adduction of 40 degrees, extension of 40 degrees, internal rotation of 75 degrees, external rotation of 75 degrees, and flexion of 90 degrees. There was a positive sign of crepitus. Neer's, Hawkins maneuver, and impingement sign were positive. O'Brien's and drop arm test were negative. Deltoid, biceps, triceps, wrist flexors, wrist extensors, and hand intrinsic were 4+ bilaterally. Deep tendon reflexes on biceps, triceps, and brachioradialis were 2+ bilaterally. Examination of the right hand revealed tenderness to palpation. There was a positive Tinel's sign. There was moderate decrease in sensation noted over the median distribution. Motor strength of the hand was rated at a 3/5. It was noted in the progress note that the injured worker stated that the medications were helping. The treatment plan is for the injured worker to undergo acupuncture sessions to the right shoulder, acquire bilateral Pro Wrist supports, and continue the use of medications. The provider would also like to have an MRI done of the right shoulder. The rationale and Request for Authorization form were not submitted for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Acupuncture 8 visits 2x4 right shoulder, 8 visits 2x4 right hand:** Upheld

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

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

**Decision rationale:** The request for Acupuncture 8 visits 2 times 4 for the right shoulder, 8 visits 2 times 4 for the right hand is not medically necessary. Acupuncture is used as an option when pain medication is reduced or not tolerated, and must be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. Frequency and duration of acupuncture or acupuncture with electrical stimulation may be performed as followed: (1) time to produce functional improvement is 3 to 6 treatments, (2) frequency is 1 to 3 times per week, and (3) optimum duration is 1 to 2 months. Given the above, the injured worker is not within the MTUS recommended guideline criteria. Furthermore, the submitted documentation lacked any pertinent information regarding past medical treatment on the injured worker. There was no indication that the injured worker had trialed and failed any conservative care, to include physical therapy, acupuncture, or NSAID therapy. Additionally, recommendations are for 3 to 6 treatments with a frequency of 1 to 3 weeks, the request as submitted is for 8 visits with 2 visits over a period of 4 weeks, which exceeds the recommended guidelines. As such, the request is not medically necessary.

**Bilateral Pro Wrist supports:** 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 Official Disability Guidelines (ODG) Forearm, Wrist & Hand, Splints.

**Decision rationale:** The request for Bilateral Pro Wrist supports is not medically necessary. According to ODG splints are recommended for treating displaced fractures. Immobilization is standard for fracture healing although patient satisfaction is higher with splinting rather than casting. Treating fractures of the distal radius with casting versus splinting has no clinical difference in outcome. A recent randomized controlled study concluded that prefabricated wrist working splints are highly effective in reducing wrist pain after 4 weeks of splint wearing in patients with wrist arthritis. Another study found that hand pain was also cut in half by wearing a long rigid splint every night for a year, but the splints usually didn't improve hand function or strength. The findings mean that splints have about the same effect on pain as ibuprofen, the most common drug in osteoarthritis. A small splint for pain relief during the day combined with a custom-made and rigid splint for prevention of deformities at night may be an optimal regimen. Given the above, the injured worker is not within ODG recommended criteria. The submitted report lacked any indication that the injured worker had a displaced fracture. There was also no

evidence to support that the injured worker had a diagnosis of wrist arthritis. Furthermore, according to the guidelines, splints have about the same effect on pain as ibuprofen. The provider did not provide a rationale as to why the injured worker would not benefit from the use of ibuprofen or how splinting would help the injured worker with any functional deficits. As such, the request for bilateral pro wrist supports is not medically necessary.

**App Trim, 2 capsules twice daily #120 2 bottles:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guideline (ODG) Treatment Workers Compensation (TWC)

**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: Physician Therapeutics.

**Decision rationale:** The request for App Trim, 2 capsules twice daily #120 2 bottles is not medically necessary. According to physician therapeutics, AppTrim is made up of a food which is formulated to be consumed or administered entirely under the supervision of a physician and which is intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements, based on recognized specific principals, are established by medical evaluation. To be considered for the use of this product, the person must be under the ongoing supervision of a medical professional, consisting of a proprietary formula of amino acids and polyphenol ingredients in specific proportions, for the dietary management of the metabolic processes associated with obesity, morbid obesity, and metabolic syndrome. Given the above, the medical necessity is unclear for the use of AppTrim. It is recommended that diet, exercise, and pharmacological methods need to be evaluated based on the injured worker's health status, BMI level, and history of weight loss goals and trials. The submitted documentation lacked any of this pertinent information. While AppTrim is intended for weight loss, AppTrim is not recommended by guidelines or acknowledged by the guidelines. As such, the request for App Trim, 2 capsules twice daily #120 2 bottles is not medically necessary.

**TG Hot 8/10/2/2.05% 240gm:** 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; Other muscle relaxants Page(s): 111; 113.

**Decision rationale:** The request for TG Hot 8/10/2/2.05% 240 gm is not medically necessary. TG Hot cream is a compound mixture containing Tramadol, Gabapentin, Menthol, Camphor, and Capsaicin. The injured worker complained of right shoulder, right hand, and right wrist pain. The California Medical Treatment Utilization Schedule (MTUS) Guidelines state that 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. There was little to no research to support the use of many of these agents. Any compounded product that contains at least 1 drug (or drug class) that is not recommended is not recommended. Given the above, the injured worker is not within the MTUS Guidelines. Furthermore, in the submitted report there was no documentation or indication as to where the cream would be applied and the amount. Additionally, the submitted report also lacked the efficacy of the medication. The submitted request is for a compound that per MTUS Guidelines is not recommended. As such, the request for TG Hot 8/10/2/2.05% 240gm is not medically necessary.

**MRI right shoulder:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-209.

**Decision rationale:** The request for MRI right shoulder is not medically necessary. According to ACOEM, criteria for ordering imaging studies of the shoulders: imaging study results will substantially change the treatment plan, there is emergence of a red flag or there is failure to progress in a rehabilitation program, evidence of significant tissue insult or neurological dysfunction that has been shown to be correctable by invasive treatment, and agreement by the patient to undergo invasive treatment if the presence of a correctable lesion is confirmed. Guidelines also stipulate that an imaging study may be an appropriate consideration for a patient to further evaluate potentially serious pathology, such as a possible tumor, or the clinical examination suggests the diagnosis. The submitted documentation lacked any information regarding whether the provider felt that the injured worker had any abnormalities or suggestions of serious pathology. Additionally, there were no soft tissue deficits documented in the submitted report. The submitted report also lacked any indication of emergence of a red flag. As such, the request for MRI right shoulder is not medically necessary.