MAXIMUS Federal Services

Case Number:	CM14-0150748		
Date Assigned:	10/23/2014	Date of Injury:	12/15/2010
Decision Date:	11/21/2014	UR Denial Date:	09/10/2014
Priority:	Standard	Application Received:	09/16/2014

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 Physical Medicine & Rehabilitation, has a subspecialty in Pain Medicine 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:

This is a patient with a date of injury of 12/15/10. A utilization review determination dated 9/10/14 recommends non-certification of topical medications, FCE, NCS (voltage actuated sensory), left wrist/hand MRI, ESWT, TENS, and a Cold/Heat Unit. Chiropractic and Acupuncture were modified from 12 sessions to 6 and 4 sessions respectively. 8/14/14 medical report identifies left hand/wrist pain. Has not received treatment. On exam, there is positive Tinel's and Phalen's as well as decreased sensation median nerve.

IMR ISSUES, DECISIONS AND RATIONALES

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

Gabapentin 15%/Amitriptyline 10%/Dextromethorphan 10% 180gms #1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics-Gabapentin.

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

Decision rationale: Regarding the request for Gabapentin/Amitriptyline/Dextromethorphan, CA MTUS states that topical compound medications require guideline support for all components of the compound in order for the compound to be approved. Gabapentin is not supported by the CA MTUS for topical use. Furthermore, there is no clear rationale for the use of topical medications

rather than the FDA-approved oral forms for this patient. In light of the above issues, the requested Gabapentin/Amitriptyline/Dextromethorphan is not medically necessary.

Flurbiprofen 20%/Tramadol 15% 180gms #1: Upheld

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

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

Decision rationale: Regarding the request for Flurbiprofen/Tramadol, CA MTUS states that topical compound medications require guideline support for all components of the compound in order for the compound to be approved. Topical NSAIDs are indicated for "Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment: Recommended for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. Neuropathic pain: Not recommended as there is no evidence to support use." Within the documentation available for review, none of the abovementioned criteria have been documented. Furthermore, there is no clear rationale for the use of topical medications rather than the FDA-approved oral forms for this patient. In light of the above issues, the requested Flurbiprofen/Tramadol is not medically necessary.

12 Chiropractic Treatments: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58-60.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58-60.

Decision rationale: Regarding the request for chiropractic treatment, Chronic Pain Medical Treatment Guidelines do not recommend chiropractic treatment in the management of hand/wrist injuries. In light of the above issues, the currently requested chiropractic treatment is not medically necessary.

12 Acupuncture Treatments: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: Regarding the request for acupuncture, California MTUS does support the use of acupuncture for chronic pain. Acupuncture is recommended to be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. Additional use

is supported when there is functional improvement documented, which is defined as "either a clinically significant improvement in activities of daily living or a reduction in work restrictions... and a reduction in the dependency on continued medical treatment." A trial of up to 6 sessions is recommended, with up to 24 total sessions supported when there is ongoing evidence of functional improvement. Within the documentation available for review, the current request exceeds the 6-visit trial recommended by guidelines. Unfortunately, there is no provision to modify the current request. As such, the currently requested acupuncture is not medically necessary.

Functional Capacity evaluation #1: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine, 2nd edition: chapter 7; Independent Consultations , pg 127

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Fitness for Duty Chapter, Functional Capacity Evaluation

Decision rationale: Regarding request for functional capacity evaluation, Occupational Medicine Practice Guidelines state that there is not good evidence that functional capacity evaluations are correlated with a lower frequency of health complaints or injuries. ODG states that functional capacity evaluations are recommended prior to admission to a work hardening program. The criteria for the use of a functional capacity evaluation includes case management being hampered by complex issues such as prior unsuccessful return to work attempts, conflicting medical reporting on precautions and/or fitness for modified job, or injuries that require detailed explanation of a worker's abilities. Additionally, guidelines recommend that the patient be close to or at maximum medical improvement with all key medical reports secured and additional/secondary conditions clarified. Within the documentation available for review, there is no indication that the patient is at or near MMRI and that there have been prior unsuccessful return to work attempts, conflicting medical reporting, or injuries that would require detailed exploration. In the absence of clarity regarding those issues, the currently requested functional capacity evaluation is not medically necessary.

NCS (voltage actuated sensory) right upper extremity: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Quantitative Sensory Threshold (QST) Testing and Current Perception Threshold (CPT) Testing

Decision rationale: Regarding the request for NCS (voltage actuated sensory), California MTUS does not address the issue. ODG cites that this type of testing is not recommended since it is considered experimental or investigational, as there are no quality published studies to support

any conclusions regarding the effects of this testing on health outcomes. In light of the above issues, the currently requested NCS (voltage actuated sensory) is not medically necessary.

NCS (voltage actuated sensory) left upper extremity: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Quantitative Sensory Threshold (QST) Testing and Current Perception Threshold (CPT) Testing

Decision rationale: Regarding the request for NCS (voltage actuated sensory), California MTUS does not address the issue. ODG cites that this type of testing is not recommended since it is considered experimental or investigational, as there are no quality published studies to support any conclusions regarding the effects of this testing on health outcomes. In light of the above issues, the currently requested NCS (voltage actuated sensory) is not medically necessary.

MRI of the left wrist/hand: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Treatment Index, 5th Edition, 2007, Arm and Hand - MRI

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 269. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, Wrist, and Hand and Carpal Tunnel Syndrome Chapters

Decision rationale: Regarding the request for MRI, California MTUS and ACOEM note that imaging studies to clarify the diagnosis may be warranted if the medical history and physical examination suggest specific disorders. More specifically, ODG notes that MRIs for carpal tunnel syndrome are not recommended in the absence of ambiguous electrodiagnostic studies. In general, they are supported in chronic wrist pain if plain films are normal and there is suspicion of a soft tissue tumor or Kienbck's disease. Within the documentation available for review, there is no clear indication of a condition for which an MRI is supported as noted above or another clear rationale for the use of MRI in this patient. In the absence of such documentation, the currently requested MRI is not medically necessary.

Extracorporeal Shockwave Therapy (ESWT): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, 9th Edition (web), Extracorporeal Shock Wave Therapy (ESWT), Shoulder

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Anthem Medical Policy # SURG.00045 Extracorporeal Shock Wave Therapy for Orthopedic Conditions

Decision rationale: Regarding the request for ESWT, California MTUS does not address the issue. ODG does not address the issue for the wrists. Anthem medical policy notes that ESWT for the treatment of musculoskeletal conditions is considered investigational and not medically necessary. In light of the above issues, the currently requested ESWT is not medically necessary.

Purchase of a TENS Unit: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-117.

Decision rationale: Regarding the request for TENS, Chronic Pain Medical Treatment Guidelines state that transcutaneous electrical nerve stimulation (TENS) is not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option if used as an adjunct to a program of evidence-based functional restoration. Guidelines recommend failure of other appropriate pain modalities including medications prior to a TENS unit trial. Prior to TENS unit purchase, a one-month trial should be documented as an adjunct to ongoing treatment modalities within a functional restoration approach, with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function. Within the documentation available for review, there is no documentation of failure of other conservative treatment prior to TENS and success of a one-month TENS unit trial as outlined above. In the absence of such documentation, the currently requested TENS unit is not medically necessary.

Cold/Heat Unit for 6 weeks: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Workers' Compensation, 9th Edition (web)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 265. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Carpal Tunnel Syndrome Chapter, Cold Packs, Heat Therapy, and Continuous Cold Therapy (CCT)

Decision rationale: Regarding the request for a cold/heat unit, CA MTUS and ACOEM state physical modalities, such as massage, diathermy, cutaneous laser treatment, "cold" laser treatment, transcutaneous electrical neurostimulation (TENS) units, and biofeedback have no scientifically proven efficacy in treating acute hand, wrist, or forearm symptoms. Patients' at-home applications of heat or cold packs may be used before or after exercises and are as

effective as those performed by a therapist. ODG recommends at-home local applications of cold packs first few days of acute complaints; thereafter, applications of heat therapy. However, formal cold therapy units are supported only after surgery for up to 7 days. Within the medical information made available for review, there is no documentation of a recent/pending surgery to support the use of a cold unit and/or another rationale identifying the medical necessity of a cold/heat unit over simple cold/heat packs as recommended by the CA MTUS, ACOEM, and ODG. In light of the above issues, the currently requested cold/heat unit is not medically necessary.