

Case Number:	CM14-0033209		
Date Assigned:	06/23/2014	Date of Injury:	07/05/2013
Decision Date:	09/15/2014	UR Denial Date:	02/25/2014
Priority:	Standard	Application Received:	03/17/2014

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 and Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Minnesota. 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 59-year-old male who reported an injury on 07/05/2013. The mechanism of injury was a fall. The diagnoses include sprain/strain of the right wrist, fracture of the distal radius, and residual limited range of motion. Previous treatments include a CT scan, x-rays, and medication. Within the clinical note dated 02/18/2014, it was reported the injured worker complained of right wrist pain which he rated 2/10 in severity. The injured worker reported the pain was intermittent and non-radiating. Upon the physical examination of the right wrist, the provider noted no tenderness; however, there was minimal to slight swelling. The range of motion of extension was 70/80 degrees and flexion at 60/85 degrees. The injured worker had negative Tinel's, Phalen's, and Finkelstein's tests. The provider requested a Functional Capacity Evaluation, Acupuncture treatment, MRI, Neurostimulator TENS Unit, Deprizine, Dicopanol, Fanatrex, Synapryn, Tabradol, Cyclophene, and Ketoprofen cream. However, a rationale was not provided for clinical review. The request for authorization was not provided for clinical review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Complete functional improvement measurement every 30 days/functional capacity evaluation while undergoing treatment: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Functional Improvement Measures Page(s): 49-50.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 77-89. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Fitness For Duty, Functional Capacity Evaluation.

Decision rationale: The injured worker complained of right wrist pain which he rated 2/10 in severity. He reported the pain was intermittent and non-radiating. The California MTUS/ACOEM Guidelines state it may be necessary to obtain a more precise delineation of the patient's capabilities than is available from routine physical examination; under some circumstances this is best done by ordering a Functional Capacity Evaluation of the injured worker. In addition, the Official Disability Guidelines recommend a Functional Capacity Evaluation may be used prior to admission to a work hardening program with preference for assessment tailored to a specific task or job. The Functional Capacity Evaluation is not recommended as the routine use, as part of occupational rehab or screening, or generic assessment in which the question is whether someone can do any type of job generally. There is a lack of documentation indicating the injured worker had undergone previous treatments with measurements of progress with the prior treatment. The requesting physician's rationale was not provided for the request submitted. There is lack of documentation indicating the injured worker to have any functional deficits. The provider failed to document whether he was requesting a work hardening program for the injured worker. Therefore, the request for a complete functional improvement measurement every 30 days/Functional Capacity Evaluation while undergoing treatment is not medically necessary and appropriate.

Acupuncture treatment for the right forearm/wrist in a frequency of three times per week for a period of 6 weeks: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: . The injured worker complained of right wrist pain which he rated 2/10 in severity. He reported the pain was intermittent and non-radiating. The acupuncture Medical Treatment Guidelines note acupuncture is used as an option when pain medication is reduced or not tolerated and may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. Guidelines note time to produce functional improvement is 3 to 6 treatments. There is lack of documentation indicating the injured worker was unable to tolerate pain medication or medication was reduced. The request submitted of 18 sessions exceeds the guideline's recommendation of 3 to 6 visits. Therefore, the request for acupuncture treatment for the right forearm/wrist in a frequency of 3 times per week for 6 weeks is not medically necessary and appropriate.

MRI of the right forearm/wrist: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 268-269. Decision based on Non-MTUS Citation Official

Disability Guidelines (ODG-TWC),Forearm, Wrsit & Hand (Acute & Chronic) chapter, Indications for Imaging-- MRIs (magnetic resonance imaging).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 268-269.

Decision rationale: The injured worker complained of right wrist pain which he rated 2/10 in severity. He reported the pain was intermittent and non-radiating. California MTUS/ACOEM Guidelines note for most patients presenting with true hand and wrist problems, special studies are not needed until after 4 to 6 weeks' period of conservative care and observation. Most patients improve quickly, provided red flags conditions are ruled out. If symptoms have not resolved in 4 to 6 weeks and the patient has joint effusion, serologic studies for Lyme disease, autoimmune disease may be indicated. Imaging studies to clarify the diagnosis may be warranted if the medical history and physical examination suggests specific disorders. Guidelines note MRIs are recommended for signs and symptoms of infection. There is a lack of documentation indicating the injured worker to have undergone 4 to 6 weeks of conservative care. There is lack of significant objective findings indicating the injured worker has signs and symptoms of infection. Therefore, the request for an MRI of the right forearm/wrist is not medically necessary and appropriate.

Neurostimulator TENS-EMS (extended rental) for 6 months for a period of medical necessity: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-115.

Decision rationale: The injured worker complained of right wrist pain which he rated 2/10 in severity. He reported the pain was intermittent and non-radiating. The California MTUS Guidelines do not recommend a TENS unit as a primary treatment modality. A 1 month home-based TENS trial may be considered as a non-invasive conservative option, if used as an adjunct to a program of evidence-based functional restoration. The results of studies are inconclusive; published trials do not provide information on the stimulation parameters which are most likely to provide optimum pain relief, nor do they answer questions about long-term effectiveness. There is a lack of clinical documentation indicating the injured worker had significant deficits upon the physical exam. There is a lack of documentation indicating the injured worker had undergone a previous course of conservative therapy. The documentation submitted does not support whether the injured worker had undergone an adequate trial of the TENS unit. Therefore, the request for a Neurostimulator TENS-EMS extended rental for 6 months for medical necessity is not medically necessary and appropriate.

Prescription of Deprizine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms & Cardiovascular Risk. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Proton Pump Inhibitors (PPI).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68-69.

Decision rationale: The injured worker complained of right wrist pain which he rated 2/10 in severity. He reported the pain was intermittent and non-radiating. The California MTUS Guidelines recommend that clinicians utilize the following criteria to determine if the injured worker is at risk for gastrointestinal events including over the age of 65, history of peptic ulcer, gastrointestinal bleeding, or perforation, concurrent use of aspirin, corticosteroids, and/or anticoagulants. The guidelines note the medication is used for the treatment of dyspepsia secondary to NSAID therapy. There is a lack of documentation indicating the injured worker had gastrointestinal symptoms. The documentation submitted did not indicate the injured worker had a history of peptic ulcers, gastrointestinal bleeding, or perforation. Additionally, there is a lack of documentation indicating the injured worker had a diagnosis of dyspepsia secondary to NSAID therapy. The request submitted failed to provide the frequency and quantity of the medication. There is a lack of documentation indicating the efficacy of the medication is evidenced by significant functional improvement. Therefore, the request for Deprizine is not medically necessary and appropriate.

Prescription of Dicopanol: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation drugs.com.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain, Insomnia Treatment.

Decision rationale: . The injured worker complained of right wrist pain which he rated 2/10 in severity. He reported the pain was intermittent and non-radiating. The Official Disability Guidelines note over-the-counter medications such sedating antihistamines have been suggested for sleep aids, for example, diphenhydramine, also known as Dicopanol. Tolerance seems to develop within a few days. Next-day sedation has been noted, as well as impaired psychomotor and cognitive function. Side effects include urinary retention, blurred vision, orthostatic hypotension, dizziness, palpitations, increased liver enzymes, drowsiness, dizziness, and tiredness. The guidelines recommend Dicopanol treatment only be used based on the etiology with the medication recommended below. Failure of sleep disturbances to resolve in a 7 to 10 days' period may indicate a psychiatric or medical illness. Primary insomnia is generally addressed pharmacologically. Secondary insomnia may be treated with pharmacological and/or psychological measures. There is a lack of documentation indicating the injured worker is treated for or diagnosed with insomnia. The request submitted failed to provider the frequency and quantity of the medication. In addition, there is lack of documentation indicating the

efficacy of the medication as evidence by significant functional improvement. Therefore, the request for Dicopanol is not medically necessary and appropriate.

Prescription of Fanatrex: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin Page(s): 51-52.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin Page(s): 49.

Decision rationale: The injured worker complained of right wrist pain which he rated 2/10 in severity. He reported the pain was intermittent and non-radiating. The California MTUS Guidelines state gabapentin has been shown to be effective for treatment of diabetic painful neuropathic and postherpetic neuralgia and has been considered as a first-line treatment for neuropathic pain. There is lack of documentation indicating the injured worker was treated for or diagnosed with diabetic painful neuropathy. There is lack of documentation indicating the injured worker is treated for or diagnosed with postherpetic neuralgia. The request submitted failed to provide the frequency and quantity of the medication. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. Therefore, the request for Fanatrex is not medically necessary and appropriate.

Prescription of Synapryn: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol (Ultram) Page(s): 119.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use, On-Going Management Page(s): 78.

Decision rationale: The injured worker complained of right wrist pain which he rated 2/10 in severity. He reported the pain was intermittent and non-radiating. The California MTUS Guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The guidelines note a pain assessment should include current pain, the least reported pain over the period since the last assessment, average pain, and intensity of pain after taking the opioid, and how long pain relief lasts. The guidelines recommend the use of a urine drug screen or inpatient treatment with issues of abuse, addiction, or poor pain control. The provider did not document an adequate and complete pain assessment within the documentation. There is lack of documentation indicating the medication had been providing objective functional benefit and improvement. Additionally, the use of a urine drug screen is not provided for documentation. The injured worker had been utilizing the medication since at least 07/2013. In addition, the request submitted failed to provide the frequency and quantity of the medication. Therefore, the request for Synapryn is not medically necessary and appropriate.

Prescription of Tabradol: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Cyclobenzaprine hydrochloride 1mg/ml, in oral suspension with MSM- compounding kit (<http://dailymed.nlm.nih.gov/dailymed/lookup.cfm?setid=5d19ef8b-eef3-4d52-95f5-929765ca6dc7>).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain, Compound Drugs.

Decision rationale: The injured worker complained of right wrist pain which he rated 2/10 in severity. He reported the pain was intermittent and non-radiating. The Official Disability Guidelines do not recommend compound medication as first-line therapy for most patients, but recommend as an option after a trial of first-line, FDA-approved drugs if the compound drug uses FDA-approved ingredients that are recommended. The guidelines note include at least 1 drug substance or active ingredient that is the sole active ingredient in the FDA-approved prescription drug not including over-the-counter drugs; include only bulk ingredients that are components of FDA-approved drugs that have been made in the FDA-registered facility and have an NDC code; it is not a drug that was withdrawn or removed from the market for safety reasons; is not a copy or commercially-available FDA-approved drug product; include only drug substances that have been supported as safe and effective for prescribed indications by the FDA approval process and/or by adequate medical and scientific evidence in the medical literature. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency and quantity of the medication. Therefore, the request for Tabradol is not medically necessary and appropriate.

Prescription of Cyclophene: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://rxusa.com/cgi-bin2/db/db.cgi?name2=cyclobenzaprine>.

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

Decision rationale: The injured worker complained of right wrist pain which he rated 2/10 in severity. He reported the pain was intermittent and non-radiating. The California MTUS Guidelines note topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. The guidelines note any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. In addition, the request submitted failed to provide the frequency and quantity of the medications. The guidelines do not recommend the use of topical analgesics. Therefore, the request for Cyclophene is not medically necessary and appropriate.

Prescription of Ketoprofen Cream: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 118.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical NSAIDs Page(s): 112.

Decision rationale: The injured worker complained of right wrist pain which he rated 2/10 in severity. He reported the pain was intermittent and non-radiating. The California MTUS Guidelines note topical analgesics are indicated for osteoarthritis and tendinitis, in particular, that of the knee and elbow and other joints. The guidelines note topical Non-Steroidal Anti-Inflammatory Drugs (NSAID) is recommended for short-term use of 4 to 12 weeks. There is little evidence to utilize topical analgesics for treatment of osteoarthritis of the spine, hip, or shoulder. The guidelines note Ketoprofen is non-FDA-approved for topical application. It has an extremely high incidence of photo contact dermatitis. There is a lack of documentation indicating the injured worker to be diagnosed or treated for osteoarthritis or tendinitis. Additionally, the injured worker had been utilizing the medication for an extended period of time since at least 07/2013. The request submitted failed to specify a treatment site. The request submitted failed to provide the frequency and quantity of the medication. In addition, the guidelines do not recommend the use of Ketoprofen cream for a topical application. Therefore, the request for Ketoprofen cream is not medically necessary and appropriate.