

Case Number:	CM14-0071127		
Date Assigned:	08/08/2014	Date of Injury:	08/27/2013
Decision Date:	10/14/2014	UR Denial Date:	05/08/2014
Priority:	Standard	Application Received:	05/16/2014

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 and 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 45 year old male who had a work related injury on 08/27/13. The most recent clinical documentation submitted for review was dated 07/08/14. The injured worker complained of constant right elbow pain, reported as moderate to occasionally severe. Pain radiated to his entire arm and forearm, numbness and tingling sensation, it swelled up after repetitive movements, pain increased at night and decreased with no movements when taking Naproxen was documented. Physical examination the injured worker was in no acute distress, well developed, well nourished, alert, and oriented, cooperative male with normal affect and gait, moved his right upper extremity cautiously, decreased grip strength on the right side, no instability, no laxity, no ecchymosis, no abrasions, no lacerations, and no surgical scars, mild inflammation of the right medial epicondyle, tenderness to palpation of the right medial and lateral epicondyle, range of motion of the elbow as he flexed 150 degrees on the right, extension to 0 degrees, supination and pronation 80 degrees, positive cubital Tinel sign, strength was rated 2+/5, wrist and the hand showed no instability, no laxity, no ecchymosis, no abrasion, no inflammation, no laceration, and no surgical scars, normal capillary refill, pulses were 2+ radial and ulnar, range of motion of the wrists flexion/extension was 50 degrees ulnar deviation was 30 degrees bilaterally and radial deviation 20 degrees, negative carpal Tinel, Phalen test and Finklestein. Diagnosis is listed as right medial and lateral epicondylitis, right ulnar neuritis, right upper extremity neuropathy. Current request was for acupuncture two times a week for six weeks. Transdermal compounds (unspecified), Cyclobenzaprine 7.5 milligrams quantity thirty, retrospective request for urine drug screen date of service 04/21/14, computerized range of motion/muscle testing, chiropractic treatment with chiropractic supervised physiotherapy and myofascial release one time a week for six weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

Acupuncture 2 x 6: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines, Chronic Pain Treatment Guidelines.

Decision rationale: As noted in the Acupuncture Medical Treatment Guidelines, the frequency and duration of acupuncture or acupuncture with electrical stimulation may be performed one to three times per week with an optimum duration over one to two months. Guidelines indicate that the expected time to produce functional improvement is three to six treatments. Acupuncture treatments may be extended if functional improvement is documented. Prior utilization review modified the request for acupuncture to six visits, there has been no additional clinical information submitted documenting functional improvement. Therefore, medical necessity has not been established.

Transdermal compounds, (no other information provided): Upheld

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

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

Decision rationale: As noted in the Chronic Pain Medical Treatment Guidelines, the safety and efficacy of compounded medications has not been established through rigorous clinical trials. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is no indication in the documentation that these types of medications have been trialed and/or failed. Further, California Medical Treatment Utilization Schedule (MTUS), Food and Drug Administration, and Official Disability Guidelines require that all components of a compounded topical medication be approved for transdermal use. Compounded medications contain medication ingredients which have not been approved for transdermal use. In addition, there is no evidence within the medical records submitted that substantiates the necessity of a transdermal versus oral route of administration. Therefore this compound cannot be recommended as medically necessary as it does not meet established and accepted medical guidelines. The request was nonspecific.

Cyclobenzaprine 7.5mg, qty 30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for pain) Page(s): 63. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Chapter

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril) Page(s): 41.

Decision rationale: As noted in the Chronic Pain Medical Treatment Guidelines, muscle relaxants are recommended as a second line option for short term (less than two weeks) treatment of acute low back pain and for short term treatment of acute exacerbations in patients with chronic low back pain. Studies have shown that the efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. Based on the clinical documentation, the patient has exceeded the two to four week window for acute management also indicating a lack of efficacy if being utilized for chronic flare ups. As such, the medical necessity of this medication cannot be established at this time.

Retrospective request for Urine drug screen, DOS 04/21/14: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Drug testing Page(s): 43.

Decision rationale: As noted in the Chronic Pain Medical Treatment Guidelines drug testing is recommended as an option. It is noted that using a urine drug screen to assess for the use or the presence of illegal drugs is an option. Urine drug screens are recommended as a tool to monitor compliance with prescribed substances, identify use of undisclosed substances, and uncover diversion of prescribed substances. The test should be used in conjunction with other clinical information when decisions are to be made to continue, adjust or discontinue treatment. Patients at low risk of addiction/aberrant behavior should be tested within six months of initiation of therapy and on a yearly basis thereafter. Patients at moderate risk for addiction/aberrant behavior are recommended for point of contact screening two to three times a year with confirmatory testing for inappropriate or unexplained results. Patients at high risk of adverse outcomes may require testing as often as once per month. As such, the request for retrospective request for urine drug screen, date of service 04/21/14 is not medically necessary.

Computerized range of motion/muscle testing: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back Chapter

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee chapter, Computerized muscle testing

Decision rationale: The request for computerized range of motion/muscle testing is not medically necessary. The clinical documentation submitted for review does not support the

request. The physical examination does not indicate significant changes in strength and range of motion to warrant this request. The request does not indicate which body part is to be tested. As such, medical necessity has not been established.

**Chiropractic treatment with chiropractic supervised physiotherapy and myofascial release
1 x 6: 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 6; Pain, Suffering and the Restoration of Function, page 114; Official Disability Guidelines

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 59.

Decision rationale: The request for chiropractic treatment with chiropractic supervised physiotherapy and myofascial release once a week for six weeks is not medically necessary. The clinical documentation submitted for review does not support the request. The request does not indicate which body part is to be treated, as such medical necessity has not been established.