MAXIMUS Federal Services

Case Number:	CM14-0098894		
Date Assigned:	07/28/2014	Date of Injury:	03/01/2014
Decision Date:	09/10/2014	UR Denial Date:	06/11/2014
Priority:	Standard	Application Received:	06/27/2014

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 Family 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 42 year-old female injured worker who reported an industrial injury on 03/01/2014, six months ago; attributed to the performance of her job tasks as a waitress. The patient reported an incident which resulted in a fracture to the left wrist which was treated with surgical intervention. The patient complained of constant pain to the left wrist rated as 7/10. The patient also complained of numbness and tingling in the fingers and reported that her pain was worsening. The patient reported she did not take pain medication. The objective findings on examination included tenderness to the left wrist, medial and lateral tenderness left wrist, Tinel's sign positive left wrist, healed incision volar aspect left wrist, wrist dorsi flexion of left 35 degrees, Palmer extension 30 degrees, diminished radial deviation and ulnar deviation, diminished pronation and supination. The diagnosis was status post left wrist fracture with surgical repair 03/07/2014 the treatment plan included a urine drug test, a wrist brace, additional physical therapy to the postoperative left wrist 3x4, and topical compounded cream flurbiprofen/lidocaine/amitriptyline 180 ml. The patient received post-operative rehabilitation physical therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy 3 times a week for 4 weeks for the left wrist: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Forearm & Wrist.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 265,Postsurgical Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Forearm & Wrist.

Decision rationale: The request for physical therapy to the wrist for a wrist fracture with a subsequent ORIF is in excess of the number of sessions of physical therapy recommended by the MTUS. The patient is documented to have received the recommended number of sessions of physical therapy directed to the left wrist subsequent to the ORIF. There is no objective evidence provided to support the medical necessity for more than the previously authorized sessions of physical therapy (PT) for the cited diagnoses over the continuation of a self-directed HEP. There is no rationale supported with objective evidence to establish why the patient has significant weakness even after the provided number of sessions of physical therapy as she should be in a self-directed home exercise program. The patient should be in a self-directed home exercise program for conditioning and strengthening as she has already received more sessions of PT/OT than is recommended by the MTUS. The MTUS recommends up to sixteen (16) sessions of physical therapy over a period of eight (8) weeks for the treatment of wrist fractures of the distal radius or ulna. There is no evidence provided that precludes the patient from participating in a self-directed home exercise program. The exercises for strengthening can be performed in a self-directed home exercise program. The request for 3x4 additional sessions of PT/OT is inconsistent with the MTUS. The request exceeds the number of PT sessions recommended by the applicable evidence based guidelines and therefore is considered not medically necessary.

Flurbiprofen 20%/Lidocaine 5%/Amitriptyline 5% Compound 180ml: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 112-113.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47,Chronic Pain Treatment Guidelines Topical Analgesics, Anti-Inflammatory Medications Page(s): 112-113; 22, 67-68. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Topical Analgesics, Topical Analgesics Compounded.

Decision rationale: There is clinical documentation submitted to demonstrate the use of the topical gels for appropriate diagnoses or for the recommended limited periods of time. It is not clear that the topical compounded medications are medically necessary in addition to prescribed oral medications. There is no provided subjective/objective evidence that the patient has failed or not responded to other conventional and recommended forms of treatment for relief of the effects of the industrial injury. Only if the subjective/objective findings are consistent with the recommendations of the ODG, then topical use of topical preparations is only recommended for short-term use for specific orthopedic diagnoses. There is no provided rationale supported with objective evidence to support the prescription of the topical compounded cream. There is no documented efficacy of the prescribed topical compounded analgesics with any assessment of functional improvement. The patient is stated to have reduced pain with the topical creams; however, there is no functional assessment and no quantitative decrease in pain documented. The use of topical NSAIDS is documented to have efficacy for only 2-4 weeks subsequent to injury and thereafter is not demonstrated to be as effective as oral NSAIDs. There is less ability

to control serum levels and dosing with the topicals. The patient is not demonstrated to have any GI issue at all with NSAIDS. There is no demonstrated medical necessity for topical NSAIDs for chronic pain for a prolonged period of time. The use of the topical gels/creams does not provide the appropriate therapeutic serum levels of medications due to the inaccurate dosing performed by rubbing variable amounts of gels on areas that are not precise. The volume applied and the times per day that the gels are applied are variable and do not provide consistent serum levels consistent with effective treatment. There is no medical necessity for the addition of gels to the oral medications in the same drug classes. There is no demonstrated evidence that the topicals are more effective than generic oral medications.The continued use of topical NSAIDs for the current clinical conditions is not otherwise warranted or demonstrated to be appropriate. There is no documented objective evidence that the patient requires both the oral medications and the topical analgesic medication for the treatment of the industrial injury. The continued use of topical NSAIDs for the current clinical conditions is not otherwise warranted or appropriate-noting the specific comment that "There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder." The objective findings in the clinical documentation provided do not support the continued prescription of for the treatment of chronic pain to the left wrist/forearm and is therefore considered not medically necessary.