

<b>Case Number:</b>	CM14-0020598		
<b>Date Assigned:</b>	05/02/2014	<b>Date of Injury:</b>	09/19/2010
<b>Decision Date:</b>	03/13/2015	<b>UR Denial Date:</b>	02/12/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/19/2014

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

### 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 52 year old female who sustained an industrial injury on September 19, 2010. She has reported pain of the left and right wrist and has been diagnosed with chronic pain, status post bilateral carpal tunnel release with residuals, carpal tunnel syndrome, subchondral cyst formation of the right wrist, right wrist joint effusion, left wrist avascular necrosis, and left wrist subchondral cyst formation. Treatment to date included pain medication and work modification. Currently the injured worker had tenderness over the median nerve channel bilaterally. On the right wrist she still had tenderness over the thenar eminence and over the metacarpophalangeal articulation. The treatment plan included medications and a aforementioned treatment plan. On February 12 2014 Utilization review non certified 12 chiropractic treatment which includes physiotherapy and myofascial release and functional restoration program, 12 acupuncture treatments, 1 range of motion and muscle strength testing, and unknown Rx transdermal compounds citing the MTUS, ACOEM, and Official Disability Guidelines.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**12 Chiropractic Treatments which includes physiotherapy and myofascial release and functional restoration program: Upheld**

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

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

**Decision rationale:** Regarding the request for chiropractic treatment, CA MTUS states that manual therapy and manipulation is not recommended in the management of carpal tunnel syndrome or other disorders of the forearm, wrist, and hand. 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, while a trial of acupuncture is supported in the management of chronic pain, the current request for a visit exceeds the 6-visit trial recommended by the CA MTUS. Unfortunately, there is no provision to modify the current request. As such, the currently requested acupuncture is not medically necessary.

## **Transdermal Compounds (240gm (lurbiprofen 25%, cyclobenzaprine 2% and 240gm gabapentin 10%, lidocaine 5%, tramadol 15%): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Medications.

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

**Decision rationale:** Regarding the request for transdermal compounds, 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. Topical lidocaine is recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). Additionally, it is supported only as a dermal patch. Muscle relaxants and antiepilepsy drugs are not supported by the CA MTUS for topical 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. Given all of the above, the requested transdermal compounds are not medically necessary.

**1 Range of motion and muscle strength testing: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation, Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 33, 89.

**Decision rationale:** Regarding the request for range of motion and muscle testing, Occupational Medicine Practice Guidelines state that physical examination should be part of a normal follow-up visit including examination of the musculoskeletal system. A general physical examination for a musculoskeletal complaint typically includes range of motion and strength testing. Within the documentation available for review, the requesting physician has not identified why he is incapable of performing a standard musculoskeletal examination for this patient, or why additional testing above and beyond what is normally required for a physical examination would be beneficial in this case. In the absence of such documentation, the currently requested range of motion and muscle testing is not medically necessary.