

Case Number:	CM15-0104833		
Date Assigned:	06/09/2015	Date of Injury:	07/29/2013
Decision Date:	07/14/2015	UR Denial Date:	05/04/2015
Priority:	Standard	Application Received:	06/01/2015

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: New York

Certification(s)/Specialty: Pediatrics, Internal Medicine

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 34-year-old male, who sustained an industrial injury on 07/29/2013. He has reported injury to the face and left wrist. The diagnoses have included left wrist sprain/strain; left wrist neuralgia; and left wrist fracture, status post open reduction internal fixation left wrist, on 08/30/2013. Treatment to date has included medications, diagnostics, splinting, physical therapy, acupuncture, shockwave therapy, and surgical intervention. Medications have included Naprosyn, Tramadol, and Prilosec. A progress note from the treating physician, dated 04/07/2015, documented a follow-up visit with the injured worker. Currently, the injured worker complains of dull and aching pain in the left wrist; pain is rated at 6/10 on the visual analog scale without medications, and at 5-6/10 with medications; left wrist pain is associated with radiating pain, tingling, and numbness to the fingers; pain has increased due to the cold weather; pain is aggravated with activities such as gripping, grasping, holding, pulling, pushing, and lifting; shockwave treatment and acupuncture are going well; and the pain is relieved with rest and medications. Objective findings included decreased JAMAR grip strength in the left hand; and tenderness to palpation of the left dorsal wrist, lateral wrist, medial wrist, and volar wrist. The treatment plan has included the request for Cyclobenzaprine 2 percent, Gabapentin 15 percent, Amitriptyline 10 percent, no quantity provided, and Capsaicin 0.025 percent, Flurbiprofen 15 percent, Gabapentin 10 percent, Menthol 2 percent, Camphor 2 percent, no quantity provided; EMG (Electromyography)/NCV (Nerve Conduction Velocity) for left wrist/hand; Shockwave therapy 1x6 left wrist; retrospective MRI left wrist (date of service: 03/25/15); Anaprox/ Naproxen 550 mg #60; and Tramadol 37.5/325 mg #60.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cyclobenzaprine 2 Percent, Gabapentin 15 Percent, Amitriptyline 10 Percent No Qty Provided and Capsaicin .025 Percent, Flurbiprofen 15 Percent, Gabapentin 10 Percent, Menthol 2 Percent, Camphor 2 Percent No Qty Provided: Upheld

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

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

Decision rationale: Cyclobenzaprine and gabapentin are not FDA approved for topical use. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. This request is not medically necessary and appropriate. Capsaicin, camphor and menthol are approved for topical use in patients who are intolerant to other treatments. Flurbiprofen, amitriptyline and gabapentin are not FDA approved for topical use. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. This request is not medically necessary and appropriate.

EMG/NCV for Left Wrist/Hand: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 238.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, Wrist, & Hand - Electrodiagnostic studies (EDS).

Decision rationale: Electro diagnostic studies are recommended as an option after closed fractures of distal radius & ulna if necessary to assess nerve injury. Also recommended for diagnosis and prognosis of traumatic nerve lesions or other nerve trauma. Electro diagnostic testing includes testing for nerve conduction velocities (NCV), and possibly the addition of electromyography (EMG). The documentation does not indicate that the IW had fractured his wrist nor that there were progressive neurologic symptoms. The request is not medically necessary.

Shockwave Therapy 1x6 Left Wrist: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Extracorporeal Shock Wave Therapy for Orthopedic Conditions.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Elbow - Extracorporeal shockwave therapy (ESWT) Ankle, Knee/Leg, Elbow - Extracorporeal shock wave therapy (ESWT).

Decision rationale: MTUS and ODG guidelines do not comment on shockwave therapy for the wrist. ODG guidelines for the elbow state that ESWT is not recommended. If the decision is made to use this treatment despite the lack of convincing evidence criteria for use are that the condition has remained despite six months of standard treatment, at least three conservative treatments have been performed prior to use of ESWT. These would include (a) Rest; (b) Ice; (c) NSAIDs; (d) Orthotics; (e) Physical Therapy; (e) Injections (Cortisone), maximum of 3 therapy sessions over 3 weeks and contraindications are patients with blood clotting diseases, infections, tumors, cervical compression, arthritis of the spine or arm, or nerve damage; Patients with cardiac pacemakers; Patients who had physical or occupational therapy within the past 4 weeks; Patients who received a local steroid injection within the past 6 weeks; Patients with bilateral pain; Patients who had previous surgery for the condition. According to the documentation, the IW is on NSAID's and had undergone physical therapy. There is no mention of a third conservative measure to treat the pain and thus the request is not medically necessary.

Retro MRI Left Wrist DOS 3/25/15: 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), Forearm/Wrist/Hand chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, Wrist, & Hand - MRIs (magnetic resonance imaging).

Decision rationale: Per ODG guidelines, MRI is recommended as indicated below. Indications for MRI include acute hand or wrist trauma, chronic wrist pain, plain films normal, suspect soft tissue tumor, or Kienbock's disease. Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. The documentation notes that the MRI was ordered for failing conservative therapy. The request is not medically necessary.

Anaprox/Naprosyn 550 MG #60: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 47. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAID's Page(s): 67-68. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) .

Decision rationale: According to the MTUS and ODG guidelines, NSAID's are recommended for osteoarthritis, chronic back pain and acute exacerbations of back pain. Per the ODG wrist

chapter over the counter medications are recommended. Specifically, acetaminophen, and NSAIDs (aspirin, ibuprofen) as a secondary choice. There is no documentation of a trial of acetaminophen or OTC NSAID's before use of a prescription NSAID. This request is not medically necessary and appropriate.

Tramadol 37.5/325 MG #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 81.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use; 4) On-Going Management; 6) When to Discontinue Opioids; 7) When to Continue Opioids for chronic pain Page(s): 78-80.

Decision rationale: The IW has been on long term opioids, which is not recommended. Additionally, documentation did not include review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. This request is not medically necessary and appropriate.