

Case Number:	CM15-0168519		
Date Assigned:	09/09/2015	Date of Injury:	09/10/2013
Decision Date:	10/13/2015	UR Denial Date:	08/14/2015
Priority:	Standard	Application Received:	08/27/2015

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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 50 year old male, who sustained an industrial injury on 9-10-2013. Diagnoses include status post left wrist and forearm blunt trauma crush injury, left distal radius complex fracture, multiple left wrist complex fractures, left ulnar neuropathy (Guyon's canal), left medial neuropathy (Carpal Tunnel), and left 5-finger flexion contracture with intrinsic tightness development. Treatment to date has included surgical intervention (left wrist arthroscopy, open reduction internal fixation (ORIF) and open TFCC repair on 1-29-2014) as well as conservative measures including modified work, diagnostics, occupational therapy, splinting and medications. Per the Orthopedic Hand Specialist Progress Report dated 6-17-2015, the injured worker presented for follow-up of left wrist pain. He reported pain in the left wrist, numbness of the left fingers with tingling sensation, weakness of the left hand and electrical shooting pain in the left hand from elbow going all the way down to fingers. Objective findings included decreased light touch in median greater than ulnar, positive median nerve compression test on the left side, and positive tenderness ulnar nerve left cubital tunnel. The plan of care included surgical intervention (left carpal tunnel surgery was requested on 12-10-2014). On 8-14-2015, Utilization Review denied the request for Tylenol #4 #90, Post-op.

IMR ISSUES, DECISIONS AND RATIONALES

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

Post op Tylenol #4 Qty: 90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Medications for chronic pain, Opioids, criteria for use, Opioids for chronic pain.

Decision rationale: The patient presents on 08/05/15 with left wrist pain rated 4/10. The patient's date of injury is 09/10/13. Patient is status post left wrist arthroscopy, extensor tenolysis of the 2nd-5th dorsal compartments with open reduction and internal fixation of the distal radius styloid process on 01/29/14. The request is for POST OP TYLENOL #4 QTY:90. The RFA is dated 08/07/15. Physical examination dated 08/05/15 reveals decreased grip strength in the left hand, and decreased and painful left wrist range of motion in all planes. The patient's current medication regimen is not provided. Patient is currently advised to return to work ASAP with modified duties. MTUS, CRITERIA FOR USE OF OPIOIDS Section, pages 88 and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS, CRITERIA FOR USE OF OPIOIDS Section, page 78 also requires documentation of the 4As (analgesia, ADLs, adverse side effects, and adverse behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. MTUS, CRITERIA FOR USE OF OPIOIDS Section, p77, states that "function should include social, physical, psychological, daily and work activities, and should be performed using a validated instrument or numerical rating scale." MTUS, MEDICATIONS FOR CHRONIC PAIN Section, page 60 states that "Relief of pain with the use of medications is generally temporary, and measures of the lasting benefit from this modality should include evaluating the effect of pain relief in relationship to improvements in function and increased activity." MTUS, MEDICATIONS FOR CHRONIC PAIN Section, pages 60 and 61 state the following: "Before prescribing any medication for pain the following should occur: (1) determine the aim of use of the medication; (2) determine the potential benefits and adverse effects; (3) determine the patient's preference." In this case, it appears that this is a prospective request for post-operative analgesia medications following an anticipated left carpal tunnel release surgery. However, it is not clear if the associated procedure has been approved. Per the most recent hand surgery consultation note, dated 08/17/15, the provider notes that the anticipated surgical procedure is "RECOMMENDED NOT AUTHORIZED." Were the provider to include documentation that this patient has obtained approval for the associated procedure, the recommendation would be for approval. However, without evidence that the requested procedure has been approved and scheduled, the associated post-operative medications are unnecessary. Therefore, the request IS NOT medically necessary.

Purchase of IF unit- electrical stimulation device: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

Decision rationale: The patient presents on 08/05/15 with left wrist pain rated 4/10. The patient's date of injury is 09/10/13. Patient is status post left wrist arthroscopy, extensor tenolysis of the 2nd-5th dorsal compartments with open reduction and internal fixation of the distal radius styloid process on 01/29/14. The request is for PURCHASE OF IF UNIT - ELECTRICAL STIMULATION DEVICE. The RFA is dated 08/07/15. Physical examination dated 08/05/15

reveals decreased grip strength in the left hand, and decreased and painful left wrist range of motion in all planes. The patient's current medication regimen is not provided. Patient is currently advised to return to work ASAP with modified duties. MTUS Chronic Pain Medical Treatment Guidelines, Transcutaneous electrotherapy section, pages 118-120, under Interferential Current Stimulation has the following regarding ICS units: "While not recommended as an isolated intervention, Patient selection criteria if Interferential stimulation is to be used anyway: Possibly appropriate for the following conditions if it has documented and proven to be effective as directed or applied by the physician or a provider licensed to provide physical medicine: Pain is ineffectively controlled due to diminished effectiveness of medications; or Pain is ineffectively controlled with medications due to side effects; or History of substance abuse; or Significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment; or Unresponsive to conservative measures (e.g., repositioning, heat/ice, etc.) If those criteria are met, then a one-month trial may be appropriate to permit the physician and physical medicine provider to study the effects and benefits. There should be evidence of increased functional improvement, less reported pain and evidence of medication reduction. A "jacket" should not be certified until after the one-month trial and only with documentation that the individual cannot apply the stimulation pads alone or with the help of another available person." In regard to the prospective request for the purchase of an IF unit for this patient's post-operative pain, evidence of a successful 30 day trial has not been provided. There is no evidence that this patient has trialed an IF unit to date. Were the request for a 30 day rental or trial the recommendation would be for approval. However, the purchase of an IF unit without first demonstrating efficacy with a 30 day trial does not meet MTUS guideline procedures and cannot be substantiated. Therefore, the request IS NOT medically necessary.