

Case Number:	CM15-0193590		
Date Assigned:	10/07/2015	Date of Injury:	03/29/2015
Decision Date:	12/14/2015	UR Denial Date:	09/02/2015
Priority:	Standard	Application Received:	10/01/2015

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: 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 32 year old female with an industrial injury date of 03-29-2015 (cumulative trauma 03-30-2014-03-30-2015). Medical record review indicates she is being treated for right elbow sprain-strain, right wrist sprain-strain, anxiety and depression. Subjective complaints (08-19-2015) included "achy, sharp" right elbow pain rated as 4-7 out of 10 and activity dependent "dull, throbbing, pins and needles" right wrist pain with radiation to right forearm and elbow rated as 4-5 out of 10. Associated symptoms included loss of strength and dropping items due to weakness. Prior treatment included at least 9 sessions of physical therapy. Objective findings (08-09-2015) included tenderness to palpation of the lateral epicondyle, medial epicondyle, olecranon process and triceps. There was tenderness to palpation of the dorsal wrist, lateral wrist, medial wrist and volar wrist. The 08-19-2015 progress note is the only progress note submitted before the utilization review decision date. Prior medications - response to medications, activities of daily living or prior MRI is not indicated in the record. On 09-02-2015 the following requests were non-certified by utilization review.- Physical Therapy 2 x 4 Right Wrist- Ortho Consult- MRI Right Elbow- Compound Rx: Gabapentin 10% Cyclobenzaprine 6%- Compound Rx: 240 gram Flurbiprofen 20% Lidocaine 5% Amitriptyline 5%

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI Right Elbow: Upheld

Claims Administrator guideline: Decision based on MTUS Shoulder Complaints 2004.
Decision based on Non-MTUS Citation ODG Elbow Chapter.

MAXIMUS guideline: Decision based on MTUS Elbow Complaints 2007,
Section(s): Diagnostic Criteria.

Decision rationale: MTUS, ACOEM, Elbow Complaints, Special Studies and Diagnostic and Treatment Considerations, pg 33 MTUS recommends imaging studies of the elbow only after a period of conservative rehabilitation program. Furthermore, imaging should be performed only when there is a presence of a red flag noted on history or examination, when the study results will substantially change the treatment plan and when there is evidence of significant tissue insult or neurological dysfunction that has been shown to be correctible by invasive treatment, and the patient agrees to undergo invasive treatment if the presence of the correctible lesion is confirmed. The injured worker complains of chronic right elbow pain. Documentation fails to show objective evidence indicating a significant change in symptoms or red flags consistent with significant tissue insult or neurological dysfunction to establish the medical necessity for imaging. The request for elbow MRI is not medically necessary per MTUS guidelines.

Compound Rx: 240 grm Flurbiprofen 20% Lidocaine 5% Amitriptyline 5%: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

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

Decision rationale: MTUS states that use of topical analgesics is primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is little to no research to support the use of many of these agents. Flurbiprofen is not FDA approved for topical application. MTUS guidelines state that non-dermal patch formulations of Lidocaine such as creams, lotions and gels, are not indicated for treatment of neuropathic pain. Per guidelines, any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The request for Compound Rx: 240 grm Flurbiprofen 20% Lidocaine 5% Amitriptyline 5% is not medically necessary.

Compound Rx: Gabapentin 10% Cyclobenzaprine 6%: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

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

Decision rationale: MTUS states that use of topical analgesics is primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is little to no research to support the use of many of these agents. MTUS does not recommend the use of topical Gabapentin or muscle relaxants. Per guidelines, any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The request for Compound Rx: Gabapentin 10% Cyclobenzaprine 6% is not medically necessary by MTUS.

Ortho Consult: Overturned

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

MAXIMUS guideline: Decision based on MTUS General Approaches 2004, Section(s): Cornerstones of Disability Prevention and Management.

Decision rationale: MTUS, ACOEM, Chapter 5, Disability, Referrals, pg 92 MTUS states that a referral may be appropriate if the practitioner is uncomfortable with treating a particular cause of delayed recovery or has difficulty obtaining information or agreement to a treatment plan. Depending on the issue involved, it often is helpful to position a behavioral health evaluation as a return-to-work evaluation. The goal of such an evaluation is functional recovery and return to work. Chart documentation indicates that the injured worker complains of persistent right wrist pain refractory to conservative management to date. The recommendation for orthopedic consult is appropriate. The request for Ortho Consult is medically necessary.

Physical Therapy 2x4 Right Wrist: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Forearm, Wrist, & Hand Chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Physical Therapy Chapter.

Decision rationale: MTUS states that active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. As time goes, one should see an increase in the active regimen of care or decrease in the passive regimen of care and a fading of treatment of frequency. When the treatment duration and/or number of visits exceed the guidelines, exceptional factors should be noted. MTUS and ODG guidelines recommend 9 physical therapy visits over 8 weeks for sprains and strains of the wrist and hand. Documentation indicates that the injured worker had already undergone at least 9 sessions of Physical Therapy. Given that the injured worker has not had significant objective improvement in physical function or pain with an initial course of physical therapy, medical necessity for additional physical therapy has not been established. Per guidelines, the request for Physical Therapy 2x4 Right Wrist is not medically necessary.