

Case Number:	CM15-0055276		
Date Assigned:	04/09/2015	Date of Injury:	02/28/2012
Decision Date:	05/19/2015	UR Denial Date:	02/23/2015
Priority:	Standard	Application Received:	03/23/2015

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, Arizona

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 61-year-old female who reported an injury on 02/28/2012. The mechanism of injury was not provided. Diagnoses included carpal tunnel syndrome, unspecified site, unspecified derangement of joint, radial styloid tenosynovitis in other specified sites of the shoulder and upper arm. Medications included creams, ibuprofen 800 mg, and Prilosec 20 mg. Surgical history was not provided. Diagnostic studies included an MRI of the right wrist that showed probably TFCC tear, de Quervain's tendonitis; MRI of the left wrist showed de Quervain's tendonitis. Other therapies were noted to include medications. On 12/01/2014, the injured worker was seen for wrist pain. The injured worker does not use assistive device or supports. Motor strength is 5+/5 bilaterally in the upper and lower extremities. The injured worker's pain was rated 5/10 in the right wrist. Pain in the left wrist was rated 3/10 to 4/10. Pain in the bilateral shoulders was rated 6/10. On examination, there was decreased range of motion in the bilateral shoulders. There was tenderness to palpation of the dorsal wrist and volar wrist. Tinel's was positive, Finkelstein's was positive, reverse Phalen's caused pain, bilateral shoulders had tenderness to palpation at the anterior shoulder, FROM, 5/5 muscle strength, empty can test, and cross arm test were positive. The treatment plan included refill creams; ibuprofen 800 mg; Prilosec 20 mg; 180 g capsaicin 0.025%, flurbiprofen 15%, gabapentin 10%, menthol 2%, camphor 2% apply thin layer 3 times per day for left shoulder, right shoulder, left wrist, and right wrist; 180 g cyclobenzaprine 25, gabapentin 15%, amitriptyline 10% apply thin layer 3 times a day for left shoulder, right shoulder, left wrist, and right wrist; refer to NCV/EMG for left shoulder, right shoulder, left wrist, right wrist; refer to urinalysis testing; and treatment to include

acupuncture 1 time a week for 6 weeks for the left shoulder, right shoulder, left wrist, and right wrist. The Request for Authorization was not provided within the documentation submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physiotherapy 6 sessions 1 x 6: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine.

Decision rationale: The request for physiotherapy 6 sessions 1 x 6 is not supported. The injured worker had a history of wrist pain. The California MTUS Guidelines state patients are instructed and expected to continue active therapies at home as an extension of the therapy process in order to maintain improvement levels. The injured worker has had previous physical therapy. There is a lack of documentation of objective functional benefit from previous therapy. There is a lack of documentation of remaining deficits. There is a lack of documentation as to the necessity of supervised therapy over independent home exercise therapy. The body part therapy is to be performed on was not provided within the request. As such, the request is not medically necessary.

V-SNCT Upper Extremities: 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); Low back Chapter, Current perception threshold testing, Neck Chapter Voltage actuated sensory nerve conduction and Current perception threshold testing.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck & Upper Back, Voltage actuated sensory nerve conduction testing.

Decision rationale: The request for V-SNCT upper extremities is not supported. The injured worker had a history of wrist pain. The Official Disability Guidelines for neck and upper back do not recommend the SNCT. There are no clinical studies demonstrating the quantitative test of sensation improved the management in clinical outcomes of patient quantitative methods of sensory testing. The American Academy of Neurology and the American Association of Electrodiagnostic Medicine have both concluded that quantitative sensory threshold testing standards need to be developed and that there is as of yet insignificant evidence to validate the use of current perception threshold testing. There is a lack of documentation from the provider of a rationale for the upper extremity of this modality for the injured worker. As such, the request is not medically necessary.

Capsaicin 0.025%, Flurbiprofen 15%, Gabapentin 10%, Menthol 2%, Camphor 2% QTY 180gm: 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): 111-116.

Decision rationale: The request for capsaicin 0.025%, flurbiprofen 15%, gabapentin 10%, menthol 2%, camphor 2% QTY 180gm is not supported. The injured worker had a history of wrist pain. The California MTUS Guidelines state capsaicin is recommended only as an option in patients who have not responded or are intolerant to other treatments. There is a lack of documentation that the injured worker is unresponsive to other treatments. The guidelines state NSAIDs are indicated for osteoarthritis and tendonitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment. NSAID topicals are recommended for short-term use, up to 12 weeks. There is a lack of documentation as to the amount of time the patient has been on said cream. There is a lack of documentation as to why the injured worker cannot take oral medication for pain. As for gabapentin, the guidelines state that it is not recommended and there is no evidence to support use. Any compound that contains at least 1 drug (or drug class) that is not recommended is not recommended. There is a lack of documentation as to the body part the cream is to be applied. There is a lack of documentation as to how often the cream is to be used within the request. As such, the request is not medically necessary.

Gabapentin 15%, Amitriptyline 4%, Dextromethorphan 10% QTY 180gm: 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): 111-116.

Decision rationale: The request for gabapentin 15%, amitriptyline 4%, dextromethorphan 10% QTY 180gm is not supported. The injured worker had a history of wrist pain. The California MTUS does not support topical AEDs. There is no support for the use of amitriptyline in topical formulation for any form of neuropathic pain. Dextromethorphan is FDA-approved for oral formulation. The request does not provide frequency or body part the cream is to be used on. As such, the request is not medically necessary.

Referral to RTW/Functional Capacity Evaluation testing: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines 2nd Edition,

Independent Medical Examinations and Consultations Chapter 7 and Official Disability Guidelines (ODG) Fitness for Duty Chapter, Functional Capacity Evaluation (FCE) Chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Functional restoration programs (FRPs) Page(s): 49.

Decision rationale: The request for referral to RTW/Functional Capacity Evaluation testing is not supported. The injured worker had a history of wrist pain. ACOEM Guidelines note, there is little scientific evidence confirming that FCEs predict an individual capacity to perform in the work place. ODG supports FCEs when prior unsuccessful return to work has been documented. There is a lack of documentation the injured worker attempted to return to work. The request is not medically necessary.

Urine Analysis Testing: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Screening for risk of addictions (test), Opioids, steps to avoid misuse/addiction. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)' Pain Chapter, urine drug testing (UDT).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78.

Decision rationale: The request for urine analysis testing is not supported. The injured worker had a history of wrist pain. The California MTUS Guidelines support that urine drug screening for low risk patients approximately once a year for maintaining opioid use. There is a lack of documentation that the injured worker is taking medications that would support screening and monitoring of medication compliance. As such, the request is not medically necessary.

NCV/EMG: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179.

Decision rationale: The request for NCV/EMG is not supported. The injured worker had a history of wrist pain. The California MTUS/ACOEM Guidelines state appropriate electrodiagnostic studies may help differentiate between carpal tunnel syndrome and other conditions, such as cervical radiculopathy. There is a lack of documentation to indicate subjective complaints or objective exam findings of neurological deficits. As such, the request is not medically necessary.

Orthopedic Surgeon Consultation: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM guidelines for Independent Medical Examinations and Consultations regarding Referrals, Chapter 7.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 89-92.

Decision rationale: The request for orthopedic surgical consult is not supported. The injured worker had a history of wrist pain. The California MTUS/ACOEM Guidelines state that occupational health practitioner may refer to ortho specialist when a diagnosis is uncertain or extremely complex. The injured worker had been recently certified for consultation and there is no documentation as to why the injured worker would need a second consultation at this time. As such, the request is not medically necessary.