MAXIMUS Federal Services

Case Number:	CM14-0114368		
Date Assigned:	08/04/2014	Date of Injury:	01/28/2013
Decision Date:	10/07/2014	UR Denial Date:	07/16/2014
Priority:	Standard	Application Received:	07/22/2014

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. The expert reviewer is Board Certified in Occupational Medicine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 applicant is a represented [redacted]., employee who has filed a claim for chronic neck pain, hand pain, wrist pain, carpal tunnel syndrome, and sleep disturbance reportedly associated with an industrial injury of January 28, 2013.In a utilization review report dated July 18, 2014, the claims administrator approved a urine drug screen, approved Naprosyn, approved Prilosec, denied 12 sessions of chiropractic manipulative therapy, denied a neurology consultation, denied a wrist support replacement, denied Flexeril, denied Tramadol, denied Theramine, denied Sentra, and denied various topical compounded medications.The applicant's attorney subsequently appealed.In a handwritten physical therapy progress note on March 13, 2014, it appeared that the applicant received a variety of passive modalities, including myofascial release therapy, infrared therapy, application of topical heat and cold and electrical stimulation.The applicant received many such modalities throughout various physical therapy progress notes in May 2014, apparently culminating on May 30, 2014.In a handwritten note of December 4, 2013, the applicant reported 7/10 hand and wrist pain. A wrist brace was apparently sought. The note was very difficult to follow. The applicant's work status was not clearly stated.In a progress note seemingly dated June 6, 2014, difficult to follow, not entirely legible, the applicant reported 7/10 to 8/10 wrists and hand pain, exacerbated by any kind of movement. Limited wrist range of motion is noted with a positive Phalen's sign about the wrist. Limited cervical range of motion was also noted, secondary to pain. The applicant was given diagnoses of neck pain, de Quervain's tenosynovitis, and carpal tunnel syndrome. MRI imaging of the wrist and cervical spine, 12 sessions of physical therapy, an orthopedic referral, and urine toxicology testing were endorsed. The applicant was placed off of work, on total temporary disability. Various topical compounded medications were also sought on June 7, 2014. The note was extremely difficult to follow.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic therapy three (3) times four (4): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173. Decision based on Non-MTUS Citation ACOEM pain, Suffering, and the Restoration of Function Chapter, page 114; Official Disability Guidelines (ODG) Neck/Upper Back Chapter

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy Manipulation Topic. Page(s): 58.

Decision rationale: The applicant's primary pain generators are the bilateral wrists and forearms. However, as noted on page 58 of the MTUS Chronic Pain Medical Treatment Guidelines, manipulative therapy is specifically deemed "not recommended" for issues involving the hand, wrist, and forearm. Therefore, the request is not medically necessary.

Neurology consultation: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM page 127; Official Disability Guidelines (ODG) Low Back Chapter

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

Decision rationale: As noted in the MTUS-adopted ACOEM Guidelines in Chapter 5, page 92, referral may be appropriate when an attending provider is uncomfortable with treating a particular cause of delayed recovery. In this case, the applicant's primary treating provider, a general practitioner, may, in fact, be uncomfortable treating issues associated with paresthesias of the hands and digits, likely a function of carpal tunnel syndrome. Obtaining the added expertise of a physician who does specialize in neurologic issues, such as a neurologist, is therefore indicated. Accordingly, the request is medically necessary.

Right wrist support replacement: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Carpal Tunnel Syndrome Chapter

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 264.

Decision rationale: The operating diagnosis here appears to be that of carpal tunnel syndrome. As noted in the MTUS-adopted ACOEM Guidelines in Chapter 11, Table 11-4, page 264, splinting of the wrist in a neutral position day and night is recommended as an option in the treatment of carpal tunnel syndrome, as is seemingly present here. Replacement wrist support is therefore indicated in an effort to try and treat the same. Therefore, the request is medically necessary.

Cyclobenzaprine 7.5mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine Topic. Page(s): 41.

Decision rationale: As noted on page 41 of the MTUS Chronic Pain Medical Treatment Guidelines, the addition of Cyclobenzaprine or Flexeril to other agents is not recommended. In this case, the applicant is, in fact, using a variety of other agents, including Tramadol, an opioid agent. Adding Cyclobenzaprine or Flexeril to the mix is not recommended. Therefore, the request is not medically necessary.

Tramadol 150mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 79-81. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines When To Continue Opioids Topic. Page(s): 80.

Decision rationale: The request in question represents a renewal request. However, as noted on page 80 of the MTUS Chronic Pain Medical Treatment Guidelines, the cardinal criteria for continuation of opioid therapy include evidence of successful return to work, improved functioning, and/or reduced pain achieved as a result of the same. In this case, the applicant is off of work, on total temporary disability. The applicant's pain complaints appear to be heightened from visit to visit. The applicant's pain complaints are consistently described as 7/10 or greater, despite ongoing Tramadol usage. The attending provider has not outlined any quantifiable decrement in pain or material improvements in function achieved as a result of ongoing Tramadol usage. Therefore, the request is not medically necessary.

Theramine #90 (2 bottles): 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) Pain Chapter

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Alternative Treatment Section..

Decision rationale: The MTUS does not address the topic. However, as noted in the Third Edition ACOEM Guidelines, Chronic Pain Chapter, dietary supplements such as Theramine are "not recommended" in the treatment of chronic pain as they have not been demonstrated to have any meaningful benefits or favorable outcomes in the treatment of the same. Therefore, the request is not medically necessary.

Sentra AM #60: 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) Pain Chapter

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Alternative Treatment Section..

Decision rationale: The MTUS does not address the topic. As noted in the Third Edition ACOEM Guidelines, Chronic Pain Chapter, dietary supplements such as Sentra AM are not recommended in the treatment of chronic pain as they have not been demonstrated to have any meaningful benefits or favorable outcomes in the treatment of the same. No applicant-specific rationale or medical evidence was furnished to offset the unfavorable ACOEM position on the dietary supplement at issue. Therefore, the request is not medically necessary.

Sentra PM #60: 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) Pain Chapter

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Alternative Treatment Section..

Decision rationale: The MTUS does not address the topic. As noted in the Third Edition ACOEM Guidelines, Chronic Pain Chapter, alternative treatments and/or dietary supplements such as Sentra PM are not recommended in the treatment of chronic pain as they have not been demonstrated to have any meaningful benefits or favorable outcomes in the treatment of the same. Therefore, the request is not medically necessary.

Compounded medication: Flurbiprofen 10%, Capsaicin 0.025%, Camphor 2%-120 grams: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Capsaicin Topic,Topical Analgesics Topic. Page(s): 28, 111.

Decision rationale: As noted on page 28 of the MTUS Chronic Pain Medical Treatment Guidelines, capsaicin, one of the ingredients in the compound, is not recommended except as a last-line agent, in applicants who have not responded to or are intolerant of other treatments. In this case, there is no clearly stated evidence of intolerance to and/or failure of multiple classes of first-line oral pharmaceuticals so as to justify usage of the capsaicin-containing topical compound at issue. Since the capsaicin ingredient in the compound is not recommended, the entire compound is not recommended, per page 111 of the MTUS Chronic Pain Medical Treatment Guidelines. Therefore, the request is not medically necessary.

Compounded medication: Ketoprofen 10%, Cyclobenzaprine 3%, Lidocaine 5%-120 grams: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 112-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Topic. Page(s): 111-112.

Decision rationale: As noted on page 112 of the MTUS Chronic Pain Medical Treatment Guidelines, Ketoprofen, the primary ingredient in the compound in question, is not recommended for topical compound formulation purposes. Since one or more ingredients in the compound are not recommended, the entire compound is not recommended, per page 111 of the MTUS Chronic Pain Medical Treatment Guidelines. Therefore, the request is not medically necessary.