

<b>Case Number:</b>	CM14-0133945		
<b>Date Assigned:</b>	08/27/2014	<b>Date of Injury:</b>	08/14/2012
<b>Decision Date:</b>	10/14/2014	<b>UR Denial Date:</b>	07/31/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/21/2014

### 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 Anesthesiology, has a subspecialty in Pain 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 injured worker is a 42 year old female who had a work related injury on 08/14/2012. She reports that there was no specific injury on this date. She explains it was around that time she experienced an increase of pain in her hands, shoulders and neck right greater than left. Her treatment has consisted of lumbar epidural steroid injection, left carpal tunnel release in April 2013 with good improvement, including 80-90% reduction in pain. She has undergone arthroscopy of her shoulder on the right in February 2014. She reports that her right shoulder has improved greatly since her recent surgery. Electrodiagnostic testing on 09/26/12 revealed normal EMG studies of the cervical spine and upper extremities. NCV tests revealed mild bilateral carpal tunnel syndrome. Most recent medical record submitted for review is dated 07/01/14. The injured worker is being seen for orthopedic evaluation. She is one week following right carpal tunnel release. She is doing well. She denies any fever, chills or other signs or symptoms of infection. She has noted improvement in paresthesias. Physical examination of the right hand and wrist notes a well approximated healing surgical incision in the palmar aspect of the hand consistent with prior carpal tunnel release. Sutures are in place. There is no significant swelling or erythema, warmth, discharge or dehiscence. The injured worker can touch all fingertips to the middle plantar crease and the tip of the thumb to the fifth metacarpal head. Diagnoses status post carpal tunnel release, status post right shoulder arthroscopy for subacromial decompression, status post left carpal tunnel release, musculoligamentous strain, cervical spine, extreme morbid obesity, low back pain, status post sural nerve injury in right foot. Prior utilization review on 07/31/14 was non-certified. There was a utilization review done prior to the last utilization review where the request for postoperative physical therapy 3 x week x 4 weeks was modified to certified 6 postop therapy sessions. There has been no indication those therapy sessions have been completed and no documentation of objective functional improvement if they were.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Twelve (12) sessions of postoperative physical therapy for the right hand/wrist:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM), 2nd Edition, (2004) Chapter 11, page(s) 264.

**Decision rationale:** The request for twelve (12) sessions of postoperative physical therapy for the right hand/wrist is not medically necessary. The clinical documentation submitted for review does not support the request. There was a utilization review done prior to the last utilization review where the request for postoperative physical therapy 3 x week x 4 weeks was modified to certified 6 postop therapy sessions. There has been no indication those therapy sessions have been completed and no documentation of objective functional improvement if they were. As such, medical necessity has not been established.

**Zanaflex 2mg 1 bid #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Muscle relaxants (for p.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines , Muscle relaxants (for pain Page(s): , page(s) 63.

**Decision rationale:** As noted on page 63 of the Chronic Pain Medical Treatment Guidelines, muscle relaxants are recommended as a second-line option for short-term (less than two weeks) treatment of acute low back pain and for short-term treatment of acute exacerbations in patients with chronic low back pain. Studies have shown that the efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. Based on the clinical documentation, the patient has exceeded the 2-4 week window for acute management also indicating a lack of efficacy if being utilized for chronic flare-ups. As such, the medical necessity of this medication cannot be established at this time.

**Ultracin lotion apply bid-tid 120 grams:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Topical analgesics.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesic Page(s): page(s) 111.

**Decision rationale:** The safety and efficacy of compounded medications has not been established through rigorous clinical trials. Topical analgesics are primarily recommended for

neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is no indication in the documentation that these types of medications have been trialed and/or failed. This compound is noted to contain capsaicin, menthol, and methyl salicylate. There is no indication in the documentation that the patient cannot utilize the readily available over-the-counter version of this medication without benefit. As such, the request for this compound cannot be recommended as medically necessary.