

Case Number:	CM14-0149987		
Date Assigned:	09/18/2014	Date of Injury:	11/11/2013
Decision Date:	11/20/2014	UR Denial Date:	08/15/2014
Priority:	Standard	Application Received:	09/15/2014

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 Physical Medicine and Rehabilitation 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 45-year-old male who reported an injury on 11/11/2013. Working for [REDACTED] in the capacity of a dental/denture plaster technician, he sustained injury to left wrist, hand, and forearm while in the normal course of his work duties. The injured worker's treatment history included physical therapy, medications, cold packs, MRI study of the left wrist, x-rays of left wrist. The injured worker had undergone a left wrist MRI arthrogram on 01/21/2014 that revealed peripheral and central portions of triangular fibrocartilage complex are intact. Moderate tendinitis and longitudinal split tears of the extensor carpi radialis tendon, with moderate tenosynovitis, mild cystic change within the lunate which may represent subcortical cystic change or interosseous ganglion. The injured worker had undergone a left wrist x-ray on 11/13/2013 that was normal. The injured worker was evaluated on 06/11/2014 and it was documented that the injured worker complained of left elbow pain and muscle spasm, bilateral wrist and hand pain and muscle spasms. He also complained of weakness, numbness, tingling, and pain radiating to the hands and fingers. Physical examination revealed +2 tenderness to palpation at the lateral epicondyle and at the ulnar groove. There was also tenderness to palpation at the extensor muscle compartments, decreased left elbow range of motion, positive Cozen's sign and cubital Tinel's. There was +2 tenderness to palpation at the triangular fibrocartilage complex. There was +1 tenderness at the carpal tunnel. There was tenderness to palpation over the carpal bones and over the thenar and hypothenar eminence bilaterally. Decreased wrist range of motion bilaterally. Positive TFCC load test bilaterally. Sensory to pin prick was diminished along the course of ulnar nerve distribution in the left upper extremity. Medications included Terocin patches, Cyclobenzaprine/Ketoprofen cream, Tabradol/Synapryn, Fanatrex, Dicopanol, and Deprizine. Diagnoses included cubital tunnel syndrome, ulnar nerve lesion, triangular fibrocartilage tear, lateral epicondylitis/bilateral tennis elbow, wrist sprain/strain, wrist

tenosynovitis, and elbow sprain/strain. The injured worker had undergone MRI of the right hand and MRI of the left wrist on 07/25/2014, that revealed extensor and flexor tendons along the dorsal and volar aspect of the hand are unremarkable. Thenar and hypothenar muscles, dorsal and palmar interossei lumbricals and adjacent soft tissues appear normal. Carpo-metacarpal, metacarpophalangeal, and interphalangeal joints appear normal with normal articular surfaces. The palmar and collateral ligaments do not reveal any obvious abnormality. Flexor and extensor tendons are seen in the dorsoventral aspect of his wrist joint. These revealed normal signal intensity. Normal alignment of carpal bones is maintained. Scapholunate angle appears normal. No evidence of radio carpal instability was noted. The Request for Authorization dated 06/11/2014 was for extracorporeal shock wave therapy. The request dated 06/17/2014 was for acupuncture sessions, MRI scan of left wrist and hand, x-ray of left wrist, hot/cold unit, TENS unit with supplies, Terocin patches, Cyclobenzaprine/Ketoprofen cream, Tabradol/Synapryn oral suspension, Fanatrex, Dicopanol, Deprizine, and physical therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Acupuncture three times per week for six weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: The request for acupuncture three times per week for six weeks is not medically necessary. Per the Acupuncture Medical Treatment Guidelines, it is stated Acupuncture Medical Treatment Guidelines state that "acupuncture" is used as an option when pain medication is reduced or not tolerated; it may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. It is the insertion and removal of filiform needles to stimulate acupoints (acupuncture points). Needles may be inserted, manipulated, and retained for a period of time. Acupuncture can be used to reduce pain, reduce inflammation, increase blood flow, increase range of motion, decrease the side effect of medication-induced nausea, promote relaxation in an anxious patient, and reduce muscle spasm. The guidelines state that the frequency and duration of acupuncture with electrical stimulation may be performed to produce functional improvement for up to 3 to 6 treatments no more than 1 to 3 times per week with duration of 1 to 2 months. Acupuncture treatments may be extended if functional improvement is documented. According to the records submitted indicated the injured worker has received acupuncture sessions and physical therapy sessions. Additionally, there were no long-term goals or outcome measures of prior conservative care the injured worker has received. Documents that were submitted indicated the injured worker has had conservative treatment to include physical therapy, however, the outcome measurements were not submitted for this review. Additionally, the request that was submitted failed to include body location where the injured worker needs acupuncture treatment. As such, the request for acupuncture three times per week for six weeks is not medically necessary.

MRI (Magnetic Resonance Imaging) scan of left wrist and hand: 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) (Minnesota Rules, 5221.6100 Parameters for Medical Imaging)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 268-269.

Decision rationale: The request for MRI, bilateral wrists, is not medically necessary. The American College of Occupational and Environmental Medicine state that special studies for most patients presenting with true hand and wrist problems, special studies are not needed until after a 4-6 week period of conservative care and observation. Most patients improve quickly provided any red flag conditions are ruled out. If symptoms have not resolved in 4-6 weeks and the patient has joint effusion, serologic studies for Lyme disease and autoimmune diseases may be indicated. Imaging studies to clarify the diagnosis may be warranted if the medical history and physical examination suggests specific disorders. The documents submitted for review indicated the injured worker had an MRI of the wrist and hand on 07/25/2014. The provider failed to indicate rationale for a repeat MRI of the wrist/hand. As such, the request for MRI (Magnetic Resonance Imaging) scan of the left wrist and hand is not medically necessary.

X-ray of left wrist: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 268. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Forearm, Wrist, and Hand Chapter

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 268-269.

Decision rationale: The request is not medically necessary. The American College of Occupational and Environmental Medicine state that special studies for most patients presenting with true hand and wrist problems, special studies are not needed until after a 4-6 week period of conservative care and observation. Most patients improve quickly provided any red flag conditions are ruled out. If symptoms have not resolved in 4-6 weeks and the patient has joint effusion, serologic studies for Lyme disease and autoimmune diseases may be indicated. Imaging studies to clarify the diagnosis may be warranted if the medical history and physical examination suggests specific disorders. The injured worker had an MRI of the hand/left wrist on 07/25/2014. The provider failed to indicate the rationale why he was requesting an x-ray of the left wrist, and an MRI study that just had been done on 07/25/2014. As such, the request for x-ray of the left wrist is not medically necessary.

Hot/Cold unit: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation PubMed-indexed for MEDLINE -PMID: 18214217

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 265-266.

Decision rationale: The request is not medically necessary. The American College of Occupational and Environmental Medicine (ACOEM) state that forearm, wrist, and hand, physical modalities such as massage, diathermy, cutaneous laser treatment, cold laser treatment, transcutaneous electrical nerve stimulation (TENS unit), and biofeedback have no scientifically proven efficiency in treating acute hand, wrist, or forearm symptoms. Limited studies suggest that there are satisfying short term, medium term effects due to ultrasound treatment in patients with mild to moderate idiopathic CTS, but the effect is not curative. Patients at home application of heat or cold packs may be used before or after exercises and are as effective as those performed by a therapist. The provider failed to indicate the rationale why the injured worker is requiring a hot/cold unit. Furthermore, the request that was submitted failed to indicate the body part where hot and cold unit is required for the injured worker. As such, the request for a hot/cold unit is not medically necessary.

TENS (Transcutaneous Electrical Nerve Stimulation) unit with supplies: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS, Chronic Pain (Transcutaneous Electrical Nerve Stimulation) P.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for the use of TENS Page(s): 114-116.

Decision rationale: The requested is not medically necessary. The MTUS Chronic Pain Medical Treatment Guidelines does not recommend a tens unit as a primary treatment modality, but a one-month home-based Tens trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence based functional restoration and other ongoing pain treatment including medication usage. It also states that the tens unit is recommended for neuropathic pain including diabetic neuropathy and post-herpetic neuralgia. The guidelines recommends as a treatment option for acute post-operative pain in the first thirty days post-surgery. The injured worker had previous massage therapy and chiropractic treatment, the outcome measurements were not provided. The provider failed to indicate long- term functional restoration goals for the injured worker. In addition, the request failed to indicate frequency and location where the TENS unit should be used on the injured worker. Given the above, the request for a TENS (transcutaneous electrical nerve stimulation) unit with supplies is not medically necessary.

Terocin patches: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111, 112-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Salicylate, Topical Analgesic, Lidocaine Page(s): 105, 111, 112.

Decision rationale: The requested is not medically necessary. The California MTUS indicates that topical analgesics are largely experimental in use with few randomized control trials to determine efficacy or safety... are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed...Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The California MTUS guidelines indicate that topical Lidocaine (Lidoderm) may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI antidepressants or an anti-epilepsy drugs such as Gabapentin or Lyrica). ...No other commercially approved topical formulations of Lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. California MTUS guidelines recommend treatment with topical salicylates. The provider failed to indicate the injured worker failing antidepressants and anticonvulsants. Additionally, the request failed to indicate where Terocin patches are required for the injured worker. The request failed to indicate duration, quantity, and frequency of Terocin patches. As such, the request for Terocin patches is not medically necessary.

Cyclobenzaprine / Ketoprofen cream: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111, 112-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine, Topical Analgesics, Ketoprofen Page(s): 41, 111, 113.

Decision rationale: The requested is not medically necessary. The California MTUS indicates topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety... are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed...Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. California MTUS guidelines do not recommend the topical use of Cyclobenzaprine as topical muscle relaxants as there is no evidence for use of any other muscle relaxant as a topical product. The addition of Cyclobenzaprine to other agents is not recommended. Regarding the use of Ketoprofen: This agent is not currently FDA approved for a topical application. The provider failed to indicate the injured worker failing antidepressants or anticonvulsants. Additionally, the request failed to include duration, frequency, and quantity of medication. As such, the request for Cyclobenzaprine/Ketoprofen cream is not medically necessary.

Tabradol/Synapryn oral suspension: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Daily Med (<http://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?id+20039>)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use, Tramadol, Cyclobenzaprine (Flexeril) Page(s): 78, 113, 41.

Decision rationale: The request is not medically necessary. The California Medical Treatment Utilization Schedule (MTUS) guidelines do not recommend tramadol as a first-line oral analgesic. The criteria for use for ongoing- management of opioids include ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. There was lack of evidence of opioid medication management and average pain, intensity of pain, or longevity, of pain relief. In addition, the request does not include the frequency. In addition, there lack of evidence of outcome measurements of conservative care such as, physical therapy or home exercise regimen outcome improvements noted for the injured worker. The documentation submitted for review there was no a urine drug screen submitted to indicate Opioids compliance for the injured worker. The request submitted failed to indicate frequency and duration of medication. Given the above, the request for Synapryn 10 mg/1ml oral suspension 500ml is not supported by the California Medical Treatment Utilization Schedule (MTUS) Guidelines recommendations. As such, the request is non-certified. According California (MTUS) Chronic Pain Medical Guidelines recommends Flexeril as an option, using a short course therapy. Cyclobenzaprine (Flexeril) is more effective than placebo in the management of back pain; the effect is modest and comes at the price of greater adverse effects. The effect is greatest in the first 4 days of treatment, suggesting that shorter courses may be better. Treatment should be brief. There is also a post-op use. The addition of Cyclobenzaprine to other agents is not recommended. Cyclobenzaprine-treated patients with fibromyalgia were 3 times as likely to report overall improvement and to report moderate reductions in individual symptoms, particularly sleep. Cyclobenzaprine is closely related to the tricyclic antidepressants and amitriptyline. The documentation submitted lacked evidence of outcome measurements of conservative care such as prior physical therapy sessions and medication pain management. There was lack of documentation provided on her long term-goals of functional improvement of him home exercise regimen. In addition, the request lacked frequency, quantity and duration of the medication. As such, the request for Tabradol/Synapryn oral suspension is not medically necessary.

Fanatrex: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation National Library of Medicine (<http://www.ncbi.nlm.nih.gov/pubmed/PMH0000704>)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines specific drug list, Gabapentin, Page(s): 16.

Decision rationale: The request is not medically necessary. The California MTUS guidelines indicate that Gabapentin is shown to be effective for treatment of diabetic painful neuropathy and post herpetic neuralgia and has been considered as a first-line treatment for neuropathic pain. There is a lack of documentation of efficacy and functional improvement with the use of this medication. In addition, it was not indicated how long the injured worker had been utilizing this medication. Moreover, the request does not indicate a frequency, dosage and quantity of medication. As such, request for Fanatrex is not medically necessary.

Dicopanol: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation National Library of Medicine (<http://www.ncbi.nlm.nih.gov/pubmed/PMH0000704>)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic) Insomnia Treatment.

Decision rationale: This request is not medically necessary. According to Official Disability Guidelines (ODG) state that over-the-counter medications such as Dicopanol are sedating antihistamines have been suggested for sleep aids (for example, diphenhydramine). Tolerance seems to develop within a few days. Next-day sedation has been noted as well as impaired psychomotor and cognitive function. Side effects include urinary retention, blurred vision, orthostatic hypotension, dizziness, palpitations, increased liver enzymes, drowsiness, dizziness, grogginess and tiredness. The documents submitted for review failed to indicate the long-term functional goals for the injured worker to include medication management. The request failed to indicate frequency, duration, dosage of medication. As such, the request for Dicopanol is not medically necessary.

Deprizine: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation National Library of Medicine (<http://www.ncbi.nlm.nih.gov/pubmed/PMH000094/>)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Proton pump inhibitors Page(s): 68-69.

Decision rationale: The request is not medically necessary. Prilosec is recommended for patients taking NSAIDs who are at risk of gastrointestinal events. The documentation submitted did not indicate the injured worker having gastrointestinal events. The provider failed to indicate the frequency and quantity medication on the request that was submitted. In addition, the provider failed to indicate long term functional goals or medication pain management outcome measurements for the injured worker. The request failed to include frequency, duration, and dosage of medication. As such, the request for Deprizine is not medically necessary.

Extracorporeal shockwave therapy once per week for six to twelve weeks: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 235. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Extracorporeal Shockwave Therapy (ESWT)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 271-273, 33-40.

Decision rationale: The requested is not medically necessary. According to the California MTUS/ACOEM guidelines EMS/Tens units are not recommended for wrist. The guidelines strongly recommended against shock wave therapy for the wrist and hand. The authors concluded that "despite improvement in pain scores and pain-free maximum grip strength within groups, there does not appear to be a meaningful difference between treating lateral epicondylitis with extracorporeal shock wave therapy combined with forearm-stretching program and treating with forearm-stretching program alone, with respect to resolving pain within an 8-week period of commencing treatment." The second high-quality study evaluated 272 patients with at least 6 months of conservative treatment (135 received ESWT and 137 received placebo ESWT) and found that ESWT as "applied in the present study was ineffective in the treatment of lateral epicondylitis." One of the meta-analyses reviewed two studies, concluding "no added benefit of ESWT over that of placebo in the treatment of LE [lateral epicondylitis]." The other review analyzed nine studies (the studies reviewed above) and concluded that "when data were pooled, most benefits were not statistically significant. No difference for participants early or late in the course of condition." Quality studies are available on extracorporeal shockwave therapy in acute, sub-acute, and chronic lateral epicondylalgia patients and benefits have not been shown. This option is moderately costly, has some short-term side effects, and is not invasive. Thus, there is a recommendation against using extracorporeal shockwave therapy. The guidelines do not recommend this procedure to be done on the wrist or hand. In addition, the documents submitted indicated the injure worker having conservative care, however there was no indication of failed outcome measurements. The request failed to indicate what body part extracorporeal therapy is required for the injured worker. As such, the request for extracorporeal shockwave therapy once per week for six to twelve weeks is not medically necessary.

Physical therapy three times per week for six weeks: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM) Practice Guidelines: Pain Suffering and the Restoration of Function Chapter, Page 114

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

Decision rationale: The request is not medically necessary. The California MTUS Guidelines may support up to 10 visits of physical therapy for the treatment of unspecified myalgia and myositis to promote functional improvement. The documents submitted indicated the injured worker has had conservative care to include additional and post-op physical therapy she had some improvement, but essentially reached a point of maximum medical improvement. However, the provider failed to indicate outcome measurements of home exercise regimen. The provider failed to indicate long-term functional goals and outcome measurements. In addition the request will exceed recommended amount of visits per the guideline. The request failed to include frequency and location where physical therapy is required for the injured worker. Given the above, the request for physical therapy three times per week for six weeks is not medically necessary.

FCE (Functional Capacity Evaluation): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM) Practice Guidelines, page 48

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Functional Capacity Evaluation Chronic Pain

Decision rationale: The request for the functional capacity evaluation is not medically necessary. In the Official Disability Guidelines state that a functional capacity evaluation is recommended prior to admission a work hardening program, with reference for assessments tailored to specific task or job. It also states if a worker is actively participating in determining the suitability of a particular job, the functional capacity evaluation is more likely to be successful. A functional capacity evaluation is not effective when the referral is less collaborative and more directive. Per the Official Disability guidelines to consider a functional capacity evaluation would be prior unsuccessful return to work attempts, conflicting medical reporting on precautions and/or fitness for modified job all key medical reports and conditions are clarified and MMI/ all key medical reports are secured. There is lack of evidence provided on 05/15/2014 why the injured worker needs a functional capacity evaluation. There is no evidence of a complex issues in the documented provided preventing the injured worker to return back to work. In addition, there were no outcome measurements indicating the injured worker had failed conservative care such as, physical therapy, functional limitations medication treatment. Given the above, the request for a functional capacity evaluation on the injured worker is not medically necessary.