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| Case Number: | CM15-0115448 | | |
| Date Assigned: | 06/23/2015 | Date of Injury: | 05/29/2013 |
| Decision Date: | 07/24/2015 | UR Denial Date: | 05/21/2015 |
| Priority: | Standard | Application Received: | 06/16/2015 |

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: Texas, New York, California
 Certification(s)/Specialty: Preventive Medicine, Occupational 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 applicant is a represented 32-year-old [REDACTED] [REDACTED] who has filed a claim for chronic wrist pain reportedly associated with an industrial injury of May 29, 2013. In a Utilization Review report dated May 21, 2015, the claims administrator approved an orthopedic evaluation, denied a topical compound, and denied a hot and cold unit purchase. The claims administrator referenced a May 7, 2015 progress note in its determination. The applicant's attorney subsequently appealed. On May 7, 2015, the applicant reported ongoing complaints of wrist pain, 3-7/10, exacerbated by gripping, grasping, pushing, pulling, and lifting. The applicant was given diagnoses of wrist sprain and triangular fibrocartilage tear. An orthopedic consultation to address the reported triangular fibrocartilage tear was sought. The topical compounded medication in question was renewed. The attending provider sought authorization for a hot and cold therapy device. Work restrictions were endorsed, although it was not clearly stated whether the applicant was or was not working with said limitations in place.

IMR ISSUES, DECISIONS AND RATIONALES

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

Flurbiprofen 10%/Gabapentin 6%/ Baclofen 2%/ Lidocaine 4%/ Cyclobenzaprine 2%:
 Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47, Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: No, the flurbiprofen-gabapentin-baclofen-lidocaine-cyclobenzaprine compound was not medically necessary, medically appropriate, or indicated here. As noted on page 113 of the MTUS Chronic Pain Medical Treatment Guidelines, baclofen, the tertiary ingredient in the compound, is not recommended for topical compound formulation purposes. Since one or more ingredients in the compound is not recommended, the entire compound is not recommended, per page 111 of the MTUS Chronic Pain Medical Treatment Guidelines. It is further noted that the attending provider did not state why what page 111 of the MTUS Chronic Pain Medical Treatment Guidelines deems largely experimental topical compounds were sought in favor of what the MTUS Guideline in ACOEM Chapter 3, page 47 deems first-line oral pharmaceuticals. Therefore, the request was not medically necessary.

Purchase of Hot/ Cold Unit for left wrist: 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) Forearm , Wrist, & Hand (Online Version).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 264. Decision based on Non-MTUS Citation ACOEM Occupational Medicine Practice Guidelines, 3rd ed., Chronic Pain, pg 968 4. Recommendation: Routine Use of Cryotherapies in Health Care Provider Offices or High Tech Devices for Any Chronic Pain Condition Routine use of cryotherapies in health care provider offices or the use of high tech devices is not recommended for treatment of any chronic pain condition. Strength of Evidence Not Recommended, Insufficient Evidence (I).

Decision rationale: Similarly, the request for a hot and cold unit [purchase] for the wrist was likewise not medically necessary, medically appropriate, or indicated here. While the MTUS Guideline in ACOEM Chapter 11, Table 11-4, page 264 does recommend at-home local applications of heat and cold as methods of symptom control for wrist, forearm, and hand complaints, as were/are present here, by implication/analogy, the MTUS Guideline in ACOEM Chapter 11, Table 11-4, page 264 does not recommend high-tech devices for delivering heat therapy and/or cryotherapy, as was sought here. The Third Edition ACOEM Guidelines takes a stronger position against high-tech devices for delivering cryotherapy, explicitly noting that such devices are not recommended in the chronic pain context present here. The attending provider failed to furnish a compelling rationale so as to offset the unfavorable ACOEM position(s) on the article at issue. Therefore, the request was not medically necessary.