MAXIMUS Federal Services

| Case Number: | CM15-0062181 | | |
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| Date Assigned: | 04/08/2015 | Date of Injury: | 10/31/2013 |
| Decision Date: | 06/01/2015 | UR Denial Date: | 03/26/2015 |
| Priority: | Standard | Application Received: | 04/01/2015 |

## 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
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 43-year-old male who sustained a work related injury October 31, 2013. Past history included carpal tunnel release and left first dorsal compartment release January 7, 2015. Prior therapies included acupuncture. The injured worker received a brace on 6/19/14. According to a doctor's first report of occupational injury or illness, dated March 11, 2015, while kneeling on the ground bolting with the right hand, ¾ inch steel cable, attached to a crane, came loose and fell, striking his lower back and fell onto the left hand. The injured worker complains of constant burning and pain in the left shoulder radiating to the left arm and hand with weakness and painful clicking and popping sensations. There is frequent severe pain in the left wrist/hand radiating into the arm and shoulder with loss of grip strength. Diagnoses are left shoulder strain with impingement and early frozen shoulder; left hand crushing injury, left carpal tunnel syndrome and left deQuervain's tenosynovitis. Treatment plan included requests for authorization for MRI of the left wrist and hand, TENS unit, functional capacity. The injured worker underwent an MRI of the left wrist on 03/26/2014, which revealed a subchondral cyst formation.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**1 TENS (transcutaneous electrical nerve stimulation) unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 265, Chronic Pain Treatment Guidelines TENS, chronic pain (transcutaneous electrical nerve stimulation). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Carpal Tunnel Syndrome (Acute & Chronic).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS unit Page(s): 114-116.

**Decision rationale:** The California Medical Treatment Utilization Schedule guideline indicate that a one month trial of a TENS unit is recommended if it is used as an adjunct to a program of evidence-based functional restoration for chronic neuropathic pain. Prior to the trial there must be documentation of at least three months of pain and evidence that other appropriate pain modalities have been tried (including medication) and have failed. The clinical documentation submitted for review failed to provide documentation the injured worker would be utilizing the unit as an adjunct to a program of evidence based functional restoration. There was a lack of documentation indicating the injured worker had failed appropriate pain modalities, including medication. The request as submitted failed to indicate whether the unit was for rental or purchase. Given the above, the request for 1 TENS (transcutaneous electrical nerve stimulation) unit is not medically necessary.

**1 left thumb wrist brace:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 263-264.

**Decision rationale:** The ACOEM Guidelines indicate that a thumb brace is recommended for the treatment of de Quervain's tenosynovitis. The clinical documentation submitted for review indicated the injured worker had a prior brace. There was lack of documentation indicating a necessity for a new brace/thumb splint. Given the above, the request for 1 left thumb wrist brace is not medically necessary.

**1 functional capacity evaluation:** 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), Functional capacity evaluations.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 89-92. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Fitness for Duty Chapter, FCE.

**Decision rationale:** The American College of Occupational and Environmental Medicine guidelines indicate there is a functional assessment tool available and that is a Functional Capacity Evaluation, however, it does not address the criteria. As such, secondary guidelines were sought. The Official Disability Guidelines indicates that a Functional Capacity Evaluation is appropriate when a worker has had prior unsuccessful attempts to return to work, has conflicting medical reports, the injured worker had an injury that required a detailed exploration of a workers abilities, a worker is close to maximum medical improvement and/or additional or secondary conditions have been clarified. The clinical documentation submitted for review failed to provide documentation the injured worker had an unsuccessful attempt to return to work. There was a lack of documentation indicating the injured worker was close to Maximum Medical Improvement. Additionally, the request was made for treatment for the left wrist and as such, secondary conditions have not been clarified. Given the above, the request for 1 Functional Capacity Examination is not medically necessary.

**1 urine drug screen:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Substance abuse (tolerance, dependence, addiction).

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

**Decision rationale:** The California MTUS indicates that the use of urine drug screening is for injured workers with documented issues of abuse, addiction, or poor pain control. The clinical documentation submitted for review failed to provide documentation that the injured worker had issues of abuse, addiction, or poor pain control. Additionally, the injured worker's medications were not submitted with the request and as such, this request would not be supported. Given the above, the request for 1 urine drug screen is not medically necessary.

**Unknown prescription of Cyclo/Tramadol compound cream:** 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, Cyclobenzaprine, Tramadol Page(s): 111, 41, 82. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: FDA.gov.

**Decision rationale:** The California Medical Treatment Utilization Schedule indicates topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. 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. They do not recommend the topical use of Cyclobenzaprine as a topical muscle relaxants as there is no evidence for use of any other muscle relaxant as a topical product. A search of the National Library of Medicine - National Institute of Health (NLM-NIH) database demonstrated no high quality human studies evaluating

the safety and efficacy of this medication through dermal patches or topical administration. A thorough search of FDA.gov, did not indicate there was a formulation of topical Tramadol that had been FDA approved. The approved form of Tramadol is for oral consumption, which is not recommended as a first line therapy. The clinical documentation submitted for review failed to provide documentation the injured worker had atrial and failure of antidepressants and anticonvulsants. There was a lack of documentation of exceptional factors to warrant nonadherence to guideline recommendations. The request as submitted failed to indicate the frequency, quantity, and body part to be treated with the topical cream. Given the above, the request for unknown prescription of Cyclo/Tramadol compound cream is not medically necessary.

**1 MRI of the left wrist/hand:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 61. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Forearm, Wrist, and Hand (Acute & Chronic), MRI.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, Wrist & Hand Chapter, MRIs (magnetic resonance imaging).

**Decision rationale:** The Official Disability Guidelines indicate a repeat MRI is not routinely recommended and should be reserved for significant change in symptoms or findings suggestive of a significant pathology. The clinical documentation submitted for review indicated the injured worker underwent a prior MRI for the left wrist/hand. There was a lack of documentation indicating the injured worker had a significant change in symptomatology or findings. The rationale for the MRI was not provided. Given the above, the request for 1 MRI of the left wrist/hand is not medically necessary.