

Case Number:	CM15-0067684		
Date Assigned:	04/15/2015	Date of Injury:	05/28/2014
Decision Date:	05/19/2015	UR Denial Date:	03/31/2015
Priority:	Standard	Application Received:	04/09/2015

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: Internal 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 injured worker is a 59 year old female with an industrial injury dated 05/28/2014. Her diagnoses include right upper extremity chronic regional pain syndrome, bilateral wrist/forearm/flexor/extensor tendonitis with de Quervain's tenosynovitis. Prior treatment includes stellate ganglion block and medications. The provider documents the injured worker presents on 03/06/2015 with improved pain in right upper extremity following stellate ganglion block. She has had one session of acupuncture. Physical exam showed tenderness of right wrist. The treatment plan included pain medications and acupuncture.

IMR ISSUES, DECISIONS AND RATIONALES

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

ADDITIONAL ACUPUNCTURE 2X3: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 265, Acupuncture Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, Wrist, & Hand (Acute &

Chronic) Acupuncture. Official Disability Guidelines (ODG) Carpal Tunnel Syndrome (Acute & Chronic) Acupuncture.

Decision rationale: Medical Treatment Utilization Schedule (MTUS) addresses acupuncture. MTUS Acupuncture Medical Treatment Guidelines state that acupuncture is used as an option when pain medication is reduced or not tolerated. The time to produce functional improvement is 3 to 6 treatments. Acupuncture treatments may be extended if functional improvement is documented. Per MTUS, functional improvement means either a clinically significant improvement in activities of daily living or a reduction in work restrictions and a reduction in the dependency on continued medical treatment. American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) Chapter 11 Forearm, Wrist, and Hand Complaints indicates that most invasive techniques, such as needle acupuncture and injection procedures, have insufficient high quality evidence to support their use. Official Disability Guidelines (ODG) Carpal Tunnel Syndrome (Acute & Chronic) indicates that acupuncture is not recommended. Systematic reviews do not recommend acupuncture when compared to placebo or control. The existing evidence is not convincing enough to suggest that acupuncture is an effective therapy for CTS. Official Disability Guidelines (ODG) Forearm, Wrist, & Hand (Acute & Chronic) indicates that acupuncture is not recommended, and systematic reviews do not recommend acupuncture when compared to placebo or control. The primary treating physician's progress report dated March 6, 2015 documented right wrist tenderness on physical examination. The request for authorization dated March 6, 2015 documented diagnosis of wrist tendinitis and De Quervain's disorder. Six additional acupuncture treatments were requested on March 6, 2015. ACOEM and ODG guidelines are not support the request for acupuncture. Therefore, the request for acupuncture is not medically necessary.

GABAPENTIN 10% CREAM APPLY BID #60GM: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page 111-113.

Decision rationale: Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines address topical analgesics. Topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. There is little to no research to support the use of many of these agents. Gabapentin is not recommended. There is no peer-reviewed literature to support use. There is no evidence for use of any other anti-epilepsy drug as a topical product. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The primary treating physician's progress report dated March 6, 2015 documented right wrist tenderness on physical examination. The request for authorization dated March 6, 2015 documented diagnosis of wrist tendinitis and De Quervain's disorder. MTUS guidelines do not support the use of topical products containing Gabapentin. Per MTUS, any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Therefore, the request for a topical analgesic

containing Gabapentin is not supported by MTUS. Therefore, the request for topical Gabapentin cream is not medically necessary.