

<b>Case Number:</b>	CM15-0099107		
<b>Date Assigned:</b>	06/01/2015	<b>Date of Injury:</b>	01/19/2010
<b>Decision Date:</b>	07/09/2015	<b>UR Denial Date:</b>	04/27/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/22/2015

### 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: New Jersey, New York  
 Certification(s)/Specialty: Family Practice

### 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 48 year old female, who sustained an industrial injury on January 19, 2010. The mechanism of injury was not provided. The injured worker has been treated for neck, back, bilateral knee and bilateral upper extremity complaints. The diagnoses have included cervical spine disc herniation, thoracic spine sprain/strain, left elbow contusion, right wrist sprain/strain, bilateral knee meniscus tear, anxiety and stress. Treatment to date has included medications, radiological studies, MRI, acupuncture treatments and physical therapy. Current documentation dated April 14, 2015 notes that the injured worker returned to work on February 23, 2015 and she states that she is having a flare up after work of neck pain, bilateral knee pain and right arm numbness and tingling, which was worse than the prior visit. Examination revealed severe tenderness to palpation of the occipital and thoracic regions. The injured worker also had moderate pain in the cervical spine and tenderness of the right wrist and left medial elbow. Cervical and lumbar range of motion was noted to be decreased. Shoulder decompression produced severe pain in the cervical spine and bilateral upper trapezius muscles bilaterally. Examination of the bilateral knees revealed a painful range of motion and a positive McMurray's sign of the left knee. The treating physician's plan of care included requests for acupuncture treatments two times a week for three weeks, interferential home unit, Flurbuprofen FCL: 20%, Tramadol 20% in 180 gm, bilateral wrist braces and a workstation re-assessment, 100 pages heavy electrical stapler and personal printer.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Acupuncture treatment (6 sessions - 2 times per week for 3 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 2 sessions per week for three weeks is medically unnecessary. By MTUS guidelines, the recommended number of sessions is 3-6 before assessing functional improvement. There has to be documented functional improvement to request more sessions. There is no reasoning documented for requesting additional sessions and there was also no documentation of the patient's response to previous acupuncture treatment. Because of these reasons, the request is not medically necessary.

**Interferential home unit: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation Page(s): pp118-120.

**Decision rationale:** The request for ICS is considered not medically necessary. The patient does not meet selection criteria. He is not documented to have failed all conservative therapy. There is no documentation that his pain was not controlled by medications or he suffered side effects that would prevent him from continuing medications. A one-month trial of ICS that demonstrated increased functional improvement and less pain, with evidence of medication reduction would be necessary before prescribing a home unit. Therefore, the request is considered not medically necessary.

**Flurbiprofen FCL: 20%/Tramadol 20% in 180gm: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111-113.

**Decision rationale:** The request is not medically necessary. The use of topical analgesics is largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when antidepressants and anticonvulsants have failed. The efficacy of topical NSAIDs is inconsistent in clinical trials. Effect seems to diminish after two weeks of treatment. It may be useful for chronic musculoskeletal pain but there are no long-term studies of its effectiveness or safety. Topical NSAIDs are not

recommended for spinal conditions. Topicals are often used when oral medications are not tolerated. There is little research to support the use of topical Tramadol in treatment of chronic pain. Long-term use has not been evaluated and cannot be recommended. Any compounded product that contains at least one drug that is not recommended is not recommended. Therefore, the request is considered not medically necessary.

**Bilateral wrist braces:** 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): 272.

**Decision rationale:** The request is considered not medically necessary. According to MTUS guidelines, splinting is first-line therapy for carpal tunnel syndrome, deQuervain's, and sprain which the patient was diagnosed with. However, according to the chart, the patient was certified for wrist braces in 3/2015. Therefore, this request is not medically necessary.

**Work station re-assessment, 100 pages heavy electrical stapler and personal printer:**  
Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 1 Prevention Page(s): 6.

**Decision rationale:** According to MTUS guidelines, the prevention of work-related injuries includes ergonomic workstation evaluation and modification. It is reasonable to request a workstation reassessment. However, according to the chart, the patient was already certified for this in 3/2015. The outcome of the evaluation was not included in the chart. Therefore, as a duplicate request, this is not considered medically necessary.