

Case Number:	CM15-0100222		
Date Assigned:	06/08/2015	Date of Injury:	03/13/2014
Decision Date:	10/15/2015	UR Denial Date:	05/01/2015
Priority:	Standard	Application Received:	05/26/2015

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: 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 injured worker (IW) is a 46 year old male who sustained an industrial injury on 03/13/2014. He reported trauma to the left forearm from having the arm caught in a roller. The injured worker was diagnosed as having ulna and distal radius fracture. Treatment to date has included open reduction and internal fixation (04/11/2014) with casting. In the April 9, 2015 examination, he also was noted to have sustained a strain in the left shoulder and a sprain in the left wrist. Currently (04/09/2015) the injured worker complains of numbness in the lateral aspect of the little finger with stiffness in the left wrist and hand. He also has ongoing pain in the left forearm and wrist that radiates to the left shoulder. He complains of constant pain in his left upper extremity from the shoulder to the hand with numbness and tingling rated a 9-10/10. Use of the arm makes the pain worse. There is stiffness in the left shoulder and pain in the left arm. He recently began to have intermittent slight pain in the lower back. Examination of the thoracolumbar spine showed mild diffuse tenderness without spasm. Active range of motion of the lumbar spine was 50% of normal. The worker complained of pain on all motions. Waddell trunk rotation test was positive, and neurological exam was normal in the lower extremities. Cervical spine range of motion was unencumbered. No spasm or tenderness was noted. Tenderness was noted diffusely about the left shoulder and there was pain on all movements. There was no pain on the right. The elbows had no scarring and all range of motion was normal. There was no tenderness around the medial or lateral epicondyles on the right. The worker complained of diffuse tenderness on the left. Elbow flexion test was negative and Tinel's was negative about the left ulnar nerve. The forearms had well healed scars on the left consistent

with open reduction internal fixation. Diffuse tenderness was present with no atrophy. The wrists and hands had full range of motion. No ganglion cysts or tenosynovitis were noted on either side. Diffuse tenderness was noted on the left with negative Grind and Finkelstein bilaterally. Carpal compression, Phalen's tests were negative bilaterally. No numbness was noted in the radial or median nerve distribution. Range of motion of the fingers and thumbs were full bilaterally. Diffuse weakness in grip was noted on the left with no weakness on the right. Electromyography studies done 12/11/2014 of the cervical spine and upper extremities were normal without evidence of radiculopathy. Nerve conduction studies showed a pattern consistent with bilateral carpal tunnel syndrome and bilateral ulnar neuropathies at the wrists consistent with constriction at Guyon's tunnel. Clinical correlation was suggested. The plan of care was for physical therapy, anti-inflammatory medications and occasional pain medications. The following requests for authorization were made. Protonix 20mg, PO once daily, #60, Tramadol ER 100mg; 1 po qd, #45, Gabapentin 10%, Amitriptyline 10%, Bupivacaine 5% Cream; Flurbiprofen 20%, Baclofen 10%, Dexamethasone 2%; Physical Therapy (12-sessions, 2 times a week for 6-weeks); Paraffin Wax Therapy (12-sessions, 2 times a week for 6-weeks); MRI of the Left Shoulder; Acupuncture (12-sessions, 2 times a week for 6-weeks); Urine Toxicology and Naproxen 550mg, #90.

IMR ISSUES, DECISIONS AND RATIONALES

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

Protonix 20mg, PO once daily, #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pantoprazole (Protonix) Page(s): 68. Decision based on Non-MTUS Citation ODG Pain Chapter, Proton Pump Inhibitors (PPIs); and on the FDA (Pantoprazole) (www.drugs.com).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68.

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines, prior to starting the patient on a proton pump inhibitor, physicians are asked to evaluate the patient and to determine if the patient is at risk for gastrointestinal events. Criteria used are: (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID. There is no documentation that the patient has any of the risk factors needed to recommend the proton pump inhibitor omeprazole. Therefore the request is not medically necessary.

Tramadol ER 100mg, 1 po qd, #45: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol (Ultram) Page(s): 82.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 113.

Decision rationale: The Chronic Pain Medical Treatment Guidelines state that continued or long-term use of opioids should be based on documented pain relief and functional improvement or improved quality of life. Tramadol is a centrally acting synthetic opioid analgesic and it is not recommended as a first-line oral analgesic. Tramadol can be added to the medication regimen, but as the immediate-release oral formulation, not as the extended-release formulation. There is no documentation supporting any functional improvement with the continued long-term use of opioids. Tramadol ER 100mg, 1 po qd, #45 is not medically necessary.

Gabapentin 10%, Amitriptyline 10%, Bupivacaine 5% Cream: Upheld

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

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

Decision rationale: According to the MTUS, there is little to no research to support the use of many of these compounded topical analgesics. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Gabapentin is not recommended. There is no peer-reviewed literature to support use. Gabapentin 10%, Amitriptyline 10%, Bupivacaine 5% Cream is not medically necessary.

Flurbiprofen 20%, Baclofen 10%, Dexamethasone 2%: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-112.

Decision rationale: According to the MTUS, there is little to no research to support the use of many of these compounded topical analgesics. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The efficacy in clinical trials for non-steroidal anti-inflammatory agents (NSAIDs) has been inconsistent and most studies are small and of short duration. Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but either not afterward, or with a diminishing effect over another 2-week period. The compounded medication requested is not recommended by the MTUS; therefore, Flurbiprofen 20%, Baclofen 10%, Dexamethasone 2% is not medically necessary.

Physical Therapy (12-sessions, 2 times a week for 6-weeks): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99. Decision based on Non-MTUS Citation ACOEM, Pain, Suffering and the Restoration of Functions Chapter, page 114.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58-60.

Decision rationale: The MTUS Chronic Pain Medical Treatment Guidelines state that active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Continued physical therapy is predicated upon demonstration of a functional improvement. There is no documentation of objective functional improvement. Therefore the request is not medically necessary.

Paraffin Wax Therapy (12-sessions, 2 times a week for 6-weeks): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Forearm, Wrist and Hand Chapter.

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 (Acute & Chronic).

Decision rationale: Recommended as an option for arthritic hands if used as an adjunct to a program of evidence-based conservative care (exercise). According to a Cochrane review, paraffin wax baths combined with exercises can be recommended for beneficial short-term effects for arthritic hands. No long-term functional improvement is expected from the use of paraffin baths. Evidence of functional improvement is required for a treatment modality to be medically necessary. In addition, the patient does not carry a diagnosis of arthritic hands. Paraffin Wax Therapy (12-sessions, 2 times a week for 6-weeks) is not medically necessary.

MRI of the Left Shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 208-209. Decision based on Non-MTUS Citation ODG Shoulder Chapter, Magnetic Resonance Imaging (MRI).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 208.

Decision rationale: According to the MTUS, the primary criteria for ordering imaging studies are emergence of a red flag, physiologic evidence of tissue insult or neurovascular dysfunction, failure to progress in a strengthening program intended to avoid surgery, or clarification of the anatomy prior to an invasive procedure. The medical record is lacking documentation in any of the above criteria. MRI of the Left Shoulder is not medically necessary.

Acupuncture (12-sessions, 2 times a week for 6-weeks): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 204, Acupuncture Treatment Guidelines. Decision based on Non-MTUS Citation ACOEM, Pain, Suffering and the Restoration of Function Chapter, page 114; and on the ODG Shoulder Chapter, Acupuncture Guidelines.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: The Acupuncture Medical Treatment Guidelines state that the initial authorization for acupuncture is for 3-6 treatments. Authorization for more than 6 treatments would be predicated upon documentation of functional improvement. The request for 12 treatments is greater than the number recommended for a trial to determine efficacy. Acupuncture (12-sessions, 2 times a week for 6-weeks) is not medically necessary.