

<b>Case Number:</b>	CM13-0057712		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	07/22/2012
<b>Decision Date:</b>	04/02/2014	<b>UR Denial Date:</b>	11/13/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/25/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation; Pain Management has a subspecialty in Interventional Spine and is licensed to practice in California. 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 patient is a 54 year old female with date of injury 7/22/12. The treating physician report dated 10/16/13 indicates the patient has right upper extremity pain due to complex regional pain syndrome. The diagnoses listed are: 1.Complex regional pain syndrome of right upper extremity 2.Fasciculations and weakness intermittent now in left upper extremity 3.Right shoulder capsulitis 4.Right elbow restriction of range of motion and function status post surgery 5.Right wrist nondisplaced chronic fracture The utilization review report dated 11/13/13 denied 6 visits chiropractic care for BUE, 6 visits hyperbaric treatment, 20 hours per week home health aide, Valium 5mg #120 and Neurontin 300mg (2 additional refills for a total of #360). The rationale for denial was based on lack of support for the requests in the guidelines.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **Six (6) Chiropractic Visits for the Bilateral Upper Extremities (BUE): Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 265.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58-59.

**Decision rationale:** The patient presents with right upper extremity pain due to complex regional pain syndrome (CRPS). The treating physician requested a referral for chiropractic care 6 visits for bilateral upper extremity pain (BUE). There is no cervical diagnosis for this patient only right upper extremity diagnoses. Chiropractic care of the cervical spine is supported in the ODG guidelines, however the documentation reviewed does not specify treatment of the cervical spine only the BUE. This request is for BUE pain. The MTUS guidelines state "Forearm, Wrist, & Hand: Not recommended." The treating physician failed to document the specific area to receive manipulation. The request is not certified.

**Six(6) visits Hyperbaric Treatment:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Hyperbaric Oxygen Therapy(HBOT).

**Decision rationale:** The patient presents with right upper extremity pain due to complex regional pain syndrome (CRPS). There is no documentation provided by the treating physician to indicate the patient is suffering with diabetic skin ulcers. The MTUS guidelines do not address the usage of Hyperbaric treatment. The ODG guidelines state that Hyperbaric Oxygen treatment (HBOT) is Recommended as an option for diabetic skin ulcers. There is no information in ACOEM, MTUS or ODG guidelines to support the usage of HBOT. Additional research was performed regarding the usage of HBOT for CRPS, however no other guidelines offered information regarding this topic. The FDA website indicates that HBOT has been cleared for thirteen uses: (HBOT is approved to treat thirteen conditions: decompression sickness, thermal burns, non-healing wounds, necrotizing soft tissue infections (a.k.a. flesh-eating bacterial disease), acute traumatic ischemias (e.g., crush injury, compartment syndrome), radiation tissue damage, smoke inhalation and carbon monoxide poisoning, air or gas embolism, severe blood loss anemia, refractory osteomyelitis, compromised skin grafts, and clostridial myonecrosis (gangrene). There is no documentation provided by the treating physician to indicate that this patient requires HBOT and it is not a nationally recognized professional standard in the treatment of CRPS. The request is not certified.

**Twenty (20) hours per week In-Home Health Aid:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines CMS, 2004 Page(s): 51.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Home Health Services.

**Decision rationale:** The patient presents with right upper extremity pain due to complex regional pain syndrome (CRPS). The treating physician notes in the 10/16/13 report that the

patient is "having increasing disability and inability to perform housekeeping, shopping, or any activities of daily living requiring simultaneous use of both hands or prolonged activity longer than 15-30 minutes." The MTUS guidelines do not address Home Health Aide. The ODG guidelines do specifically state "Recommended only for otherwise recommended medical treatment for patients who are homebound, on a part-time or "intermittent" basis, generally up to no more than 35 hours per week. Medical treatment does not include homemaker services like shopping, cleaning, and laundry, and personal care given by home health aides like bathing, dressing, and using the bathroom when this is the only care needed." The treating physician does not document that the patient requires homebound medical treatment, but instead indicates that homemaker services are becoming difficult for the patient. The ODG guidelines are clear that Home Health Services are for medical treatment only and not for homemaker services. The request is not certified.

. **Valium 5mg, #120:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

**Decision rationale:** The patient presents with right upper extremity pain due to complex regional pain syndrome (CRPS). Review of reports dated 3/6/13, 6/6/13, 8/21/13 and 10/6/13 indicate the patient has been taking valium for at least a 7 month period of time. The MTUS guidelines state "Not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. Their range of action includes sedative/hypnotic, anxiolytic, anticonvulsant, and muscle relaxant. Chronic benzodiazepines are the treatment of choice in very few conditions. The MTUS guidelines are clear that Valium is not recommended for long term use. The request is not certified.

**Neurontin 300mg (2 additional refills for a total of #360):** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin (Neurotin®).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin (Neurotin®) Page(s): 49.

**Decision rationale:** The patient presents with right upper extremity pain due to complex regional pain syndrome (CRPS). The treating physician has documented neuropathic pain with "pain continuing to be excessive in both arms, right greater than left, but with more sensitivity and allodynia and pain in the left arm again this month." The MTUS guidelines indicate that Gabapentin (Neurontin) is indicated for neuropathic pain. Recommendation is for authorization.