

<b>Case Number:</b>	CM14-0041373		
<b>Date Assigned:</b>	06/27/2014	<b>Date of Injury:</b>	08/29/2006
<b>Decision Date:</b>	08/05/2014	<b>UR Denial Date:</b>	03/14/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/07/2014

### 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. The expert reviewer is Board Certified in Orthopedic Surgery and is licensed to practice in Texas. 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/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 injured worker is a 65-year-old female who reported an injury on 08/29/2006. The mechanism of injury was not specifically stated. Current diagnoses include multilevel degenerative discopathy with foraminal narrowing, chronic cervical sprain, lumbar disc injury, status post right knee arthroscopy, left knee pain, bilateral hip pain, gastrointestinal complaints, hypertension, shoulder impingement syndrome, and carpal tunnel syndrome. The injured worker was evaluated on 02/14/2014 with complaints of significant numbness and tingling in the bilateral hands. Physical examination of the bilateral wrists and hands revealed positive Tinel's and Phalen's testing, diffuse forearm tenderness, pain upon palpation of the carpal tunnel region, moderately decreased sensation in the median nerve distribution, 2+ deep tendon reflexes, diminished strength, and limited range of motion. Treatment recommendations at that time included a right carpal tunnel release with postoperative physical therapy and prescriptions for Sprix nasal spray, Motrin 600 mg, and topical compounded creams. It is also noted that the injured worker's electrodiagnostic study on 06/19/2013 indicated normal conduction at the right and left median and ulnar nerves.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Right carpal tunnel release:** 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): 270-271.

**Decision rationale:** The California MTUS/ACOEM Practice Guidelines state referral for hand surgery consultation may be indicated for patients who have red flags of a serious nature, fail to respond to conservative management, and have clear clinical and special study evidence of a lesion. Carpal tunnel syndrome must be proved by positive findings on examination and supported by nerve conduction studies. As per the documentation submitted, the injured worker does not have electrodiagnostic evidence of carpal tunnel syndrome. Therefore, the current request cannot be determined as medically appropriate. As such, the request for Right carpal tunnel release is not medically necessary.

**Postoperative physical therapy eight (8) sessions (2x4),right wrist:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines physical medicine, Postsurgical Treatment Guidelines.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Sprix nasal spray 15.75mg 40 unite;five bottles one spray in each nostril every 6-8 hours or as directed:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation [http://www.drugs.com/pro/sprix-nasal spray](http://www.drugs.com/pro/sprix-nasal-spray).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-72.

**Decision rationale:** The California MTUS Guidelines state NSAIDs are recommended for osteoarthritis at the lowest dose for the shortest period in patients with moderate to severe pain. For acute exacerbations of chronic pain, NSAIDs are recommended as a second line option after acetaminophen. There is no indication that this injured worker is suffering from an acute exacerbation of chronic pain. There is also no indication that this injured worker cannot safely swallow pills or capsules. The medical necessity for the requested medication has not been established. As such, the request for Sprix nasal spray 15.75mg 40 unit; five bottles one spray in each nostril every 6-8 hours or as directed is not medically necessary.

**Amitramadol -DM transderm (Amitriptyline 4% Tramadol 20%Dextramethorphan 10%)240 gm:** 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 Page(s): 111-113.

**Decision rationale:** The California MTUS Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is no indication of a failure to respond to first line oral medication prior to the initiation of a topical analgesic. There is also no frequency listed in the current request. As such, the request for Amitriptyline 4% Tramadol 20% Dexamethorphan 10%) 240 gm is not medically necessary.

**Gabaketolido transderm (Gabapentin 6%ketoprofen 20%lidocaine 6.15% 240 gm: 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 Page(s): 111-113.

**Decision rationale:** The California MTUS Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Any compounded product that contains at least 1 drug that is not recommended is not recommended as a whole. The only FDA approved topical NSAID is Diclofenac. Gabapentin is not recommended. Based on the clinical information received and the California MTUS Guidelines, the request for Gabaketolido transderm (Gabapentin 6% Ketoprofen 20% Lidocaine 6.15% 240 gm is not medically necessary.