

Case Number:	CM14-0064181		
Date Assigned:	08/06/2014	Date of Injury:	04/06/2007
Decision Date:	09/10/2014	UR Denial Date:	05/02/2014
Priority:	Standard	Application Received:	05/07/2014

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 Occupational Medicine 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 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 56 year-old male with date of injury of 07/01/2006. The medical document associated with the request for authorization, a comprehensive orthopedic re-evaluation report, dated 04/15/2014, lists subjective complaints as pain in the left knee and numbness and tingling in all of the fingers. Patient stated he has had six nerve conduction/EMG studies that all showed ulnar neuropathy bilaterally, but he was not sure if it was showed median neuropathy. The objective findings are: examination of the bilateral hands, and wrists revealed ulnar nerve two-point discrimination at 8mm and bilateral median nerves at 5mm. There was some limitation of the wrists bilaterally, but he is able to make a full fist, grip strength was diminished, examination of the left knee was within normal limits. The diagnosis are: cervical herniated nucleus pulposus of C4-5 and C5-6, lumbar herniated nucleus pulposus of L2-3, status post decompression, carpal tunnel syndrome bilaterally, bilateral total knee replacement, anxiety and depression, insomnia, ulnar entrapment syndrome bilaterally left total knee replacement loosening of tibial component, and revision of left total knee replacement. Patient has attended 16 sessions of physical therapy for the left knee to date, and has achieved 0-120 degrees of range of motion. Patient is status total knee arthroplasty revision (12/11/2013). The medical records provided for review document that the patient has been taking the following medications for at least 4 months. Medications: Tramadol 150mg, #30, Prilosec 20mg, #90, Compound topical cream (Gabapentin, Ketoprofen, Tramadol) No SIG provided for the above medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tramadol 150mg, #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioid Page(s): 93-94, 113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 - 9792.26 Page(s): 113.

Decision rationale: The previous utilization review physician provided authorization for a quantity of Tramadol sufficient for weaning. 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. There is no documentation of functional improvement supporting the continued long-term use of opioids. Therefore the request is not medically necessary.

Prilosec 20mg, #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms & Cardiovascular Risk.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 - 9792.26 Page(s): 68.

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines and 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 Prilosec. Therefore the request is not medically necessary.

NCV of the Bilateral Upper Extremities, #1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): Nerve Conduction Studies.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back (Acute & Chronic), Nerve conduction studies (NCS).

Decision rationale: The Official Disability Guidelines do not recommended repeat electrodiagnostic studies to demonstrate radiculopathy if radiculopathy has already been clearly identified by EMG and obvious clinical signs, but recommended if the EMG is not clearly radiculopathy or clearly negative, or to differentiate radiculopathy from other neuropathies or non-neuropathic processes if other diagnoses may be likely based on the clinical exam. There is

minimal justification for performing nerve conduction studies when a patient is already presumed to have symptoms on the basis of radiculopathy. The patient has presumably had up to 6 previous EMG/NCS studies of the upper extremities. Therefore the request is not medically necessary.

EMG of the Bilateral Upper Extremities, #1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): Electromyography Studies.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back (Acute & Chronic), Nerve conduction studies (NCS).

Decision rationale: The Official Disability Guidelines do not recommended repeat electrodiagnostic studies to demonstrate radiculopathy if radiculopathy has already been clearly identified by EMG and obvious clinical signs, but recommended if the EMG is not clearly radiculopathy or clearly negative, or to differentiate radiculopathy from other neuropathies or non-neuropathic processes if other diagnoses may be likely based on the clinical exam. The patient has stated he has had up to 6 previous EMG/NCS studies of the upper extremities. Therefore the request is not medically necessary.

Compound Topical Cream (Gabapentin, Ketoprofen, Tramadol), #1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Compound Topical Analgesic Page(s): 111-113. Decision based on Non-MTUS Citation ODG-Compound Topical Analgesic.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 - 9792.26;Compounded Topical Analgesics 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. Therefore the request is not medically necessary.

Cervical And Wrist XForce (Solar Care): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy Page(s): 114-121.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), Electrical stimulators.

Decision rationale: The X-Force Stimulator/ Solar Care are a proprietary device that delivers a monophasic electrical current in combination with heat. According to the Official Disability Guidelines, electrical stimulators other than a TENS unit are not recommended. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. The medical record offers no documentation that the patient has undergone a trial of a TENS unit, the recommended treatment. Therefore the request is not medically necessary.

18 sessions of Physical Therapy, Left Knee: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Post Surgical Rehabilitation, Knee, Postsurgical Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 24.

Decision rationale: According to the Post-Surgical Treatment Guidelines, following a total knee procedure the patient should receive 24 postsurgical physical therapy visits over 10 weeks and 4 months of postsurgical physical medicine. The patient has attended 16 physical therapy visits. The request for 18 additional visits, if authorized, would bring the total number of visits to 34. Eighteen additional visits are not medically necessary.