

Case Number:	CM14-0072271		
Date Assigned:	07/16/2014	Date of Injury:	10/18/2013
Decision Date:	08/26/2014	UR Denial Date:	05/05/2014
Priority:	Standard	Application Received:	05/19/2014

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 Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in Tennessee. 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 patient is a 64-year-old female who has submitted a claim for reflex sympathetic dystrophy of the upper limb, other closed fractures of distal end of the radius; associated with an industrial injury date of 10/18/2013. Medical records from 2013 to 2014 were reviewed and showed that patient complained of constant aching, shooting and tender pain in the left palm as well as the web and metacarpal of the left thumb, increased sensitivity of the left hand with skin color changes, edema and sweating changes of the left hand, decreased ROM of the left hand/wrist with extension and difficulty performing ADLs due to pain and swelling. Physical examination revealed depression and anxiety, TTP to light touch of the left hand, trophic changes to the skin of the left hand, decreased ROM of the left wrist/hand and left digits and decreased strength with left grip. Treatment to date has included surgery, postoperative physical therapy and oral medications. Utilization review, dated 05/05/2014, denied the request for physical therapy because there is documentation of 26 post-operative PT sessions to date, which exceeds post-operative PT guidelines for frequency as well as postsurgical physical medicine treatment period. The same utilization review also denied the requests for Paxil and Gabapentin as there was no documentation of the amount requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy #12 sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

Decision rationale: As stated on the CA MTUS Postsurgical Treatment Guidelines, postoperative management of radial fracture supports treatment for up to 16 visits over 8 weeks. Post-surgical physical medicine treatment is 4 months. In this case, patient has had previous physical therapy, medical records show up to 26 sessions since her surgery dated 10/29/2013. The number of post-operative PT sessions has been exceeded. Therefore, the request for Physical Therapy #12 sessions is not medically necessary.

Paxil 20 mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants. Decision based on Non-MTUS Citation Official Disability Guidelines.

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

Decision rationale: The CA MTUS does not specifically address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers Compensation, and the Official Disability Guidelines (ODG) was used instead. According to the Official Disability Guidelines, Antidepressants have been found to be useful in treating depression in physically ill patients, as well as chronic headaches associated with depression. In this case, Paxil was prescribed to the patient since she has shown symptoms of anxiety, depression and documentation of chronic pain. However, there is no documentation of the amount requested to be dispensed. Therefore, the request for Paxil 20mg is not medically necessary.

Gabapentin 600mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.24.2 Page(s): 16-17.

Decision rationale: According to pages 16-17 of the CA MTUS Chronic Pain Medical Treatment Guidelines, Gabapentin has been shown to be effective for the treatment of diabetic neuropathy and post-herpetic neuralgia and has been considered as a first-line treatment for neuropathic pain. However, there are few RCTs directed at central pain and none for painful radiculopathy. In this case, Neurontin was being prescribed to the patient since there is documentation of neuropathic pain. However, the present written request failed to specify the frequency and duration of intended use. The request is incomplete. Therefore, the request for Gabapentin (duration and frequency unknown) is not medically necessary.

