

<b>Case Number:</b>	CM14-0018881		
<b>Date Assigned:</b>	02/21/2014	<b>Date of Injury:</b>	11/20/2013
<b>Decision Date:</b>	03/30/2015	<b>UR Denial Date:</b>	02/03/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/14/2014

### 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. 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: TR, California, Virginia

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 is a 53 year old female, who sustained an industrial injury on 11/20/2013. The diagnoses have included right upper extremity overuse tendinopathy and DeQuervain's tenosynovitis. Treatment to date has included injections, magnetic resonance imaging (MRI), EMG (electromyography)/NCV (nerve conduction studies), one physical therapy session, topical creams, medications and activity modification. Currently, the IW complains of pain in the right upper extremity, right wrist, right hand and fingers, as well as sleep related issues. Objective findings included diffuse tenderness in the medial and lateral epicondyles. There is decreased sensation in the median distribution of the fingers, thumb, index and long fingers. Tinel's sign is minimally positive at the elbow. Phalen's and Tinel's are mildly positive at the wrist. Thumb extension and flexion are slightly impaired by tenderness. There is a very slightly positive Finkelstein maneuver. There is swelling in the first dorsal compartment of the wrist. She received an injection of Celestone and Marcaine. On 2/03/2014, Utilization Review non-certified a request for injection of Celestone and Marcaine to the right wrist (1/15/2014), MRI of the right wrist, EMG/NCV right upper extremity, Fluriflex 15/10% 180gm cream, and TG Ice 8/10/2% 180g cream noting that the clinical information submitted for review fails to meet the evidence based guidelines for the requested service. The MTUS and ACOEM Guidelines were cited. On 2/14/2014, the injured worker submitted an application for IMR for review of Celestone and Marcaine to the right wrist (1/15/2014), MRI of the right wrist, EMG (electromyography)/NCV right upper extremity, Fluriflex 15/10% 180gm cream, and TG Ice 8/10/2% 180g cream.

## **IMR ISSUES, DECISIONS AND RATIONALES**

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

### **RETRO INJECTION OF CELESTONE AND MARCAINE RIGHT WRIST DONE**

**01/15/14:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

**Decision rationale:** According to the MTUS ACOEM guidelines, injection of corticosteroids into the carpal tunnel is recommended in mild or moderate cases of CTS after trial of splinting and medication. The guidelines recommend 8-12 weeks of conservative care prior to consideration of injection. With a date of doctor's first report listed as 11/26/13, when the patient received Tylenol and a cock-up wrist splint, and the time of the injection listed as 1/15/14, it appears that the patient underwent about seven weeks of conservative treatment prior to injection. While this is one week short of the eight week minimum per the guidelines, it is the opinion of this reviewer that a decision to inject given continued symptoms was reasonable and can be considered medically appropriate.

### **MAGNETIC RESONANCE IMAGING OF THE RIGHT WRIST:** 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. Decision based on Non-MTUS Citation Forearm, wrist, and hand

**Decision rationale:** MRI is recommended for acute hand or wrist trauma in which radiographs are normal and fracture is suspected or if wrist pain is chronic in order to rule out suspected tumor. In this case there is little evidence to warrant MRI for wrist complaints without EMG/NCV or specific neurologic deficits on exam warranting further study with MRI. Many papers dispute the value of MRI for ligamentous tears, etc. because arthroscopy is often both diagnostic and therapeutic in such cases. Given the lack of evidence to support MRI in this case based on the provided records, the request can not be considered medically necessary at this time.

### **ELECTROMYOGRAPHY RIGHT UPPER EXTREMITY:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 261.

**Decision rationale:** According to the MTUS guidelines, appropriate electrodiagnostic studies (EDS) may help differentiate between CTS and other conditions, such as cervical radiculopathy. These may include nerve conduction studies (NCS), or in more difficult cases, electromyography (EMG) may be helpful. NCS and EMG may confirm the diagnosis of CTS but may be normal in early or mild cases of CTS. If the EDS are negative, tests may be repeated later in the course of treatment if symptoms persist. Given the continued clinical exam findings and diagnostic uncertainty in this case, it is the opinion of this reviewer that obtaining EMG/NCV studies is reasonable and can be considered medically necessary.

**NERVE CONDUCTION VELOCITY UPPER RIGHT EXTREMITIES:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 261.

**Decision rationale:** According to the MTUS guidelines, appropriate electrodiagnostic studies (EDS) may help differentiate between CTS and other conditions, such as cervical radiculopathy. These may include nerve conduction studies (NCS), or in more difficult cases, electromyography (EMG) may be helpful. NCS and EMG may confirm the diagnosis of CTS but may be normal in early or mild cases of CTS. If the EDS are negative, tests may be repeated later in the course of treatment if symptoms persist. Given the continued clinical exam findings and diagnostic uncertainty in this case, it is the opinion of this reviewer that obtaining EMG/NCV studies is reasonable and can be considered medically necessary.

**FLURIFLEX 15/10% 180 GM CREAM TO APPLY A THIN LAYER TO AFFECTED AREA 2 X DAILY AS DIRECTED BY PHYSICIAN:** Upheld

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

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

**Decision rationale:** Fluriflex is a compound of flurbiprofen 15%/cyclobenzaprine 10%. The MTUS states there is little to no research to support the use of many compounded agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The use of these compounded agents requires knowledge of the specific analgesic effect of each agent and how it will be useful for the specific therapeutic goal required. The MTUS states that muscle relaxers are not recommended as topical products, and as cyclobenzaprine is a muscle relaxant not recommended by the MTUS, the request for Fluriflex cannot be considered medically necessary at this time.

**TGICE 8/10./2% 180GM CREAM APPLY A THIN LAYER TO AFFECTED AREA 2 X DAILY AS DIRECTED BY PHYSICIAN:** 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:** Gabapentin is not recommended as a topical ingredient by the MTUS, and as the guidelines state that any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended overall, the request for a compound containing Gabapentin for topical use cannot be deemed medically necessary.