

<b>Case Number:</b>	CM15-0169345		
<b>Date Assigned:</b>	09/10/2015	<b>Date of Injury:</b>	09/12/2013
<b>Decision Date:</b>	10/09/2015	<b>UR Denial Date:</b>	07/27/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/27/2015

### 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: California, Indiana, Oregon  
 Certification(s)/Specialty: Orthopedic Surgery

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This 47 year old male sustained an industrial injury to on 9-12-13. The injured worker underwent trigger finger release to the right index, long and ring finger on 4-27-15. In a PR-2 dated 7-17-15, the injured worker complained of worsening of the triggering of the right index finger with decreased range of motion, increasing numbness, tingling and shaking of the right hand and increasing weakness of the right hand. Physical exam was remarkable for definite recurrent triggering of the A1 pulley of the right index finger with positive provocative testing for median neuropathy at the right carpal tunnel and decreased sensation at the median nerve distribution on the right. Current diagnoses included status post right and third fourth finger stenosing tenosynovitis, status post right long finger release with cystic mass and recurrence, status post right ring trigger finger release with residuals, right carpal tunnel syndrome tunnel syndrome and right index finger stenosing tenosynovitis. The treatment plan included right carpal tunnel syndrome release and right index trigger finger release with associated surgical services. On 7-27-15, Utilization Review noncertified a request for Keflex noting that prophylactic antibiotics were not a supported standard of care. Utilization Review noncertified a request for Zofran noting lack of documentation of intractable nausea. Utilization Review noncertified a request for wound care cream (Fluticasone 1%, Levocetirizine 2%, Pentoxifylline 0.50%, Prilocaine 3%, and Gabapentin 15) noting lack of evidence supporting the use of topical creams to minimize scarring. Utilization Review noncertified requests for Post-op continuous passive motion (CPM) device for hand-finger movement, DVT device, for the right and left lower extremity and electrical stimulation device (purchase) citing ODG guidelines.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Cephalexin (Keflex) 500mg 1 tablet every 6 hours x 7 days #30, no refill: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Sanford Guide to Antimicrobial Therapy 2013, 43rd Edition. Authors: Gilbert, David MD, Moellering, Jr, Robert MD, Eliopoulos, George MD, Chambers, Henry MD, Saag, Michael MD. Pages 192-196; Antibiotic Prophylaxis.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Stulberg DL, Penrod MA, Blatny RA. Common bacterial skin infections. Am FamPhysician. 2002 Jul 1; 66 (1): 119-24.

**Decision rationale:** CA MTUS/ACOEM and ODG are silent on the issue of Keflex. An alternative guideline was utilized. According to the American Family Physician Journal, 2002 July 1; 66 (1): 119-125, titled "Common Bacterial Skin Infections", Keflex is often the drug of choice for skin wounds and skin infections. It was found from a review of the medical record submitted of no evidence of a wound infection to warrant antibiotic prophylaxis. The request for Keflex is therefore not medically necessary and appropriate.

**Ondansetron ODT (Zofran) 4 mg 1 tablet daily PK/30, no refill: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), TWC Pain Procedure Summary On Line Version last updated 06/15/2015.

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

**Decision rationale:** CA MTUS/ACOEM is silent on the issue of Zofran for postoperative use. According to the ODG, Pain Chapter, Ondansetron (Zofran) is not recommended for nausea and vomiting secondary to chronic opioid use. In this case the submitted records demonstrate no evidence of nausea and vomiting or increased risk for postoperative issues. Therefore determination is not medically necessary.

**Post-op wound care cream (Fluticasone 1%, Levocetirizine 2%, Pentoxifylline 0.50%, Prilocaine 3%, and Gabapentin 15%) Apply 1-3 gm to affected area 3-4 times daily (1 pump=1gm) #150 gm: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

**Decision rationale:** Per the CA MTUS regarding topical analgesics, Chronic Pain Medical Treatment Guidelines, Topical analgesics, page 111-112 "Largely experimental in use with few randomized controlled trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." Gabapentin is not recommended for topical use. Therefore the request is not medically necessary.

**Post-op continuous passive motion (CPM) device for hand/finger movement:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) TWC Forearm, Wrist & Hand Procedure Summary.

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

**Decision rationale:** CAMTUS/ACOEM is silent on the issue of continuous passive motion of the wrist. According to ODG wrist, CPM is recommended after flexor tendon repair only. As the request is for a procedure other than flexor tendon repair, the guidelines do not support its use and the request is not medically necessary.

**Post-op DVT device, for the right and left lower extremity:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) TWC Procedure Summary Online Version updated 05/05/2015.

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

**Decision rationale:** CA MTUS/ACOEM is silent on the issue of DVT compression garments. The ODG, Knee and Leg section, Compression Garments, summarizes the recommendations of the American College of Chest Physicians and American Academy of Orthopedic Surgeons. It is recommended to use of mechanical compression devices after all major knee surgeries including total hip and total knee replacements. In this patient there is no documentation of a history of increased risk of DVT or major knee surgery. The patient underwent a routine knee arthroscopy. Therefore the request is not medically necessary.

**Post-op electrical stimulation device (purchase):** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Electrical stimulators (E-stim).

**Decision rationale:** Regarding the Interferential Current Stimulation (ICS), the California MTUS Chronic Pain Medical Treatment Guidelines, Interferential Current Stimulation, pages 118-119 state, not recommended as an isolated intervention. 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 randomized trials that have evaluated the effectiveness of this treatment have included studies for back pain, jaw pain, soft tissue shoulder pain, cervical neck pain and post-operative knee pain. The findings from these trials were either negative or non-interpretable for recommendation due to poor study design and/or methodologic issues. As the request is for a treatment not recommended, it is not medically necessary.