

Case Number:	CM15-0190166		
Date Assigned:	10/02/2015	Date of Injury:	05/18/2012
Decision Date:	12/09/2015	UR Denial Date:	08/26/2015
Priority:	Standard	Application Received:	09/28/2015

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

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 54 year old female who sustained an industrial injury on 5-18-12. The medical records indicate that the injured worker is being treated for C4-5 and C5-6 disc herniation with left sided radiculopathy; L5-S1 left sided radiculopathy; knee arthritis; headaches; resolving left wrist strain; right wrist pain; right carpal tunnel syndrome, status post right carpal tunnel release. She currently (8-3-15) complains of ongoing right hand and left shoulder pain with limited activity and is postoperative carpal tunnel release. She has limited activity and function with the hand and tenderness to the palms. She has left shoulder pain from compensation. Her pain level of the right hand was 10 out of 10 on 6-2-15. On physical exam of the right hand there was sensitivity and some triggering in the middle finger, unable to touch thumb to fifth digit, decreased grip and unable to put fingers to mid palmer crease; left shoulder reveals acromioclavicular tenderness with pain, positive impingement and Hawkin's sign, range of motion was overhead reach at 150 degrees of forward flexion, on 10 degrees of abduction and 25 degrees of rotation externally; lumbar spine reveals left leg straight leg raise positive, decreased sensation at L5-S1 dermatome. On 1-29-15, she complained of low back pain radiating to both legs with numbness. Her pain level was 7 out of 10. On physical exam there were spasms and tenderness to palpation with limited range of motion. She has had electromyography-nerve conduction study (8-26-14) showing carpal tunnel syndrome; MRI of the lumbar spine (8-27-12) unremarkable. She has had 8 sessions of postoperative physical therapy after carpal tunnel release (4-15-15); medications: ketoprofen, diclofenac, gabapentin, Lidocaine 2 grams since at least 8-3-15, ibuprofen, Lyrica, Norco. The request for authorization

dated 8-3-15 was for ketoprofen, diclofenac, gabapentin, Lidocaine 2 grams; physical therapy for the bilateral upper extremities 2 times per week for 4 weeks; electromyography-nerve conduction study of the upper extremities; lumbar spine epidurals and possible right hand stellate ganglion block for complex regional pain syndrome. On 8-26-15 Utilization Review non-certified the requests for ketoprofen, diclofenac, gabapentin, Lidocaine 2 grams; physical therapy for the bilateral upper extremities 2 times per week for 4 weeks; electromyography-nerve conduction study of the upper extremities; lumbar spine epidurals and possible right hand stellate ganglion block for complex regional pain syndrome and modified to consultation only.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ketoprofen/Diclofenac/Gabapentin/Lidocaine 10/10/10/5 Cream 240gm, Apply 1-2 grams to affected area 3 to 4 times daily: 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: Regarding the request for Ketoprofen/Diclofenac/Gabapentin/Lidocaine 10/10/10/5 Cream 240gm, apply 1-2 grams to affected area 3 to 4 times daily, CA MTUS states that topical compound medications require guideline support for all components of the compound in order for the compound to be approved. Topical lidocaine is "Recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica)." Additionally, it is supported only as a dermal patch. Regarding topical gabapentin, Chronic Pain Medical Treatment Guidelines state that topical anti-epileptic medications are not recommended. They go on to state that there is no peer-reviewed literature to support their use. As such, the currently requested Ketoprofen/Diclofenac/Gabapentin/Lidocaine 10/10/10/5 Cream 240gm, Apply 1-2 grams to affected area 3 to 4 times daily is not medically necessary.

Physical Therapy; Eight (8) Sessions (2x4) Bilateral Upper Extremities: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, and Postsurgical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Carpal Tunnel Syndrome Chapter, Physical medicine treatment.

Decision rationale: Regarding the request for additional physical therapy, Chronic Pain Medical Treatment Guidelines recommend a short course of active therapy with continuation of active therapies at home as an extension of the treatment process in order to maintain improvement levels. ODG has more specific criteria for the ongoing use of physical therapy. ODG

recommends a trial of physical therapy. If the trial of physical therapy results in objective functional improvement, as well as ongoing objective treatment goals, then additional therapy may be considered. ODG recommends 1-3 visits for medical treatment of CTS. Within the documentation available for review, there is documentation of completion of prior PT sessions, but there is no documentation of specific objective functional improvement with the previous sessions and remaining deficits that cannot be addressed within the context of an independent home exercise program, yet are expected to improve with formal supervised therapy. Furthermore, the request exceeds the amount of PT recommended by the CA MTUS and, unfortunately, there is no provision for modification of the current request. In light of the above issues, the currently requested additional physical therapy is not medically necessary.

Referral to Dr for Lumbar Spine Epidurals and Possible Right Hand Stellate Ganglion Block for CRPS: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Guidelines, Independent Medical Examinations and Consultations Chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Occupational Medicine Practice Guidelines, Independent Medical Examinations and Consultations Chapter, Page 127 and State of Colorado, Chronic Pain Disorder Medical Treatment Guidelines, Exhibit Page Number 52.

Decision rationale: Regarding the request for referral to Referral to Dr for Lumbar Spine Epidurals and Possible Right Hand Stellate Ganglion Block for CRPS, California MTUS does not address this issue. ACOEM supports consultation if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. Within the documentation available for review, the patient has ongoing pain corroborated by physical exam findings. It appears there may be some remaining treatment options that have not been exhausted, and consultation with a pain management provider may help to uncover some of those options. As such, the currently requested referral to Dr for Lumbar Spine Epidurals and Possible Right Hand Stellate Ganglion Block for CRPS is not medically necessary.

EMG/NCV Studies of the Upper Extremities: Upheld

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Carpal Tunnel Syndrome Chapter, Electrodiagnostic Studies (EDS) and Electromyography.

Decision rationale: Regarding the request for EMG/NCV Studies of the Upper Extremities, Occupational Medicine Practice Guidelines state that the electromyography and nerve conduction velocities including H-reflex tests, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. Within the documentation available for review, it appears the patient has already undergone carpal tunnel surgery. It is unclear how postoperative electrodiagnostic studies will clarify the patient's current condition. Additionally, there is no documentation indicating what medical decision-making will be based upon the outcome of the request test. As such, the currently requested EMG/NCV Studies of the Upper Extremities is not medically necessary.