

Case Number:	CM15-0041629		
Date Assigned:	04/10/2015	Date of Injury:	09/04/2011
Decision Date:	05/15/2015	UR Denial Date:	02/19/2015
Priority:	Standard	Application Received:	03/05/2015

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: Orthopedic Surgery, Sports 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 52-year-old female who reported an injury on 09/04/2011. The mechanism of injury was not specifically stated. The current diagnosis is keloid scar. The injured worker presented on 01/15/2015 for a follow-up evaluation. It was noted that the injured worker was status post roller crush injury to the right upper extremity. The injured worker reported pain on the outer side of the right wrist and pain at the right thumb. There was no comprehensive physical examination provided. The physician noted no changes in the physical examination. Treatment recommendations at that time included surgical intervention. A Request for Authorization form was submitted on 02/13/2015 for excision of benign lesion with adjacent tissue rearrangement and injection of an anesthetic into the peripheral nerve.

IMR ISSUES, DECISIONS AND RATIONALES

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

Pre-op medical clearance history and physical: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 270.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Preoperative testing, general.

Decision rationale: The Official Disability Guidelines state the decision to order preoperative testing should be guided by the patient's clinical history, comorbidities, and physical examination findings. In this case, there was no documentation of a significant medical history or any comorbidities to support the necessity for preoperative medical clearance. As the medical necessity has not been established, the request is not appropriate at this time and is not medically necessary.

Keflex 500mg #30: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Infectious Disease Chapter, Cephalexin (Keflex ½).

Decision rationale: The Official Disability Guidelines recommend Keflex as a first line treatment for cellulitis and skin and soft tissue infections. While it is noted that the injured worker has been issued authorization for the excision of benign lesion with adjacent tissue rearrangement, the medical necessity for postoperative antibiotics has not been established. Intravenous prophylactic antibiotics should be given prior to the surgery. The medical rationale for additional doses of oral antibiotics following surgery was not provided. There is also no frequency listed in the request. Given the above, the request is not medically necessary.

Flurbiprofen 20% cream 30grams: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical NSAIDs.

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

Decision rationale: The California MTUS Guidelines state any compounded product that contains at least 1 drug that is not recommended is not recommended as a whole. The only FDA approved topical NSAID is diclofenac. Therefore, the request for a compounded cream containing flurbiprofen would not be supported. There is also no frequency listed in the request. As such, the request is not medically necessary.

Ketorolac: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain, Chronic.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67-72.

Decision rationale: The California MTUS Guidelines state NSAIDs are recommended for osteoarthritis at the lowest dose for the shortest period in patients with moderate to severe pain. For acute exacerbations of chronic pain, NSAIDs are recommended as a second line treatment after acetaminophen. The injured worker does not maintain a diagnosis of osteoarthritis. There is no evidence of an acute flare up of chronic pain. There is also no strength, frequency, or quantity listed in the request. Given the above, the request is not medically necessary.

Ondansetran ODT 4mg #30 x 1 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, Pain, Chronic.

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

Decision rationale: The Official Disability Guidelines do not recommend ondansetron for nausea and vomiting secondary to chronic opioid use. It has been FDA approved for nausea and vomiting secondary to chemotherapy and radiation treatment. It is also FDA approved for postoperative use. In this case, it is noted that the injured worker is scheduled for a surgical procedure. However, the medical necessity for ondansetron 4 mg #30 with 1 refill has not been established. While a short postoperative course of an antiemetic may be considered, the medical necessity for long-term use has not been established in this case. Given the above, the request is not medically necessary.

Associated surgical service: DVT device: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. 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) Shoulder Chapter, Venous Thrombosis.

Decision rationale: The Official Disability Guidelines recommend identifying patients who are at a high risk of developing a venous thrombosis and providing prophylactic measures such as anticoagulation therapy. The incidence of an upper extremity DVT is much less than that of a lower extremity. It is recommended to treat patients of asymptomatic mild upper extremity DVT with anticoagulation alone and patients of severe or extensive upper extremity DVT with a motorized mechanical device in conjunction with pharmacological thrombolysis. In this case, there was no mention of a contraindication to oral anticoagulation as opposed to a motorized mechanical device. There was no indication that this injured worker was at high risk of

developing an upper extremity DVT following surgery. The medical necessity for the requested durable medical equipment has not been established in this case. Therefore, the request is not medically necessary.

Associated surgical service: TENS unit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 265.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-117.

Decision rationale: The California MTUS Guidelines recommend postoperative transcutaneous electrical nerve stimulation as a treatment option for acute postoperative pain in the first 30 days following surgery. The proposed necessity of the unit should be documented upon request. Rental is preferred over a purchase during the initial 30 day period. In this case, the medical necessity for a postoperative TENS device has not been established. The medical rationale was not provided within the documentation submitted. There is also no frequency or treatment duration listed in the request. Guidelines recommend a 30 day rental prior to a unit purchase. Given the above, the request is not medically necessary.

Topical compound: Cyclobenzaprine 10%;Gabapentin 10% cream 30grams: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Medications.

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

Decision rationale: The California MTUS Guidelines state any compounded product that contains at least 1 drug that is not recommended is not recommended as a whole. Muscle relaxants are not recommended for topical use. Gabapentin is also not recommended as there is no peer reviewed literature to support its use as a topical product. There is also no frequency listed in the request. As such, the request is not medically necessary.