

Case Number:	CM15-0061382		
Date Assigned:	04/20/2015	Date of Injury:	06/26/2013
Decision Date:	08/25/2015	UR Denial Date:	03/24/2015
Priority:	Standard	Application Received:	04/01/2015

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

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 male, who sustained an industrial injury on 6/26/13. He reported hand and neck injuries. The injured worker was diagnosed as having discogenic cervical condition, carpal tunnel syndrome bilaterally and radioulnar joint inflammation bilaterally. Treatment to date has included left carpal tunnel release, bilateral wrist braces, TENS unit, physical therapy and activity restrictions. Currently, 2/17/15, the injured worker complains of neck and bilateral hand pain. Physical exam noted tenderness along the A1 pulley of the thumb and long finger bilaterally, weak grip and tenderness along the carpal tunnel area. The treatment plan included oral medications including Nalfon and Protonix, Tramadol, Trazodone, Flexeril and LidoPro cream, larger TENS unit, Flexeril, and surgery of right hand.

IMR ISSUES, DECISIONS AND RATIONALES

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

Associated surgical service: Polar care unit (days) qty: 21.00: 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), Knee, Hand-continuous flow cryotherapy.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, Wrist and Hand, cryotherapy.

Decision rationale: CA MTUS/ACOEM is silent on the issue of cryotherapy for the hand. According to ODG, Forearm, Wrist and Hand, cryotherapy is not recommended. Cold packs are recommended for at home application during first few days and thereafter application of heat. As the guidelines do not recommend cryotherapy for the hand, the determination is for non-certification. The request is not medically necessary.

Amoxicillin 875/125mg qty: 20.00: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM, APG I Plus, 2010, Chapter Chronic Pain.

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 Fam Physician. 2002 Jul 1;66(1):119-24.

Decision rationale: CA MTUS/ACOEM and ODG are silent on the issue of Amoxicillin. An alternative guideline was utilized. According to the American Family Physician Journal, 2002 July 1; 66 (1): 119-125, titled "Common Bacterial Skin Infections", Amoxicillin 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 Amoxicillin is therefore not medically necessary and appropriate.

Neurontin 600mg qty:90.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Specific anti-epilepsy drugs, Neurontin Page(s): 18.

Decision rationale: Per the CA MTUS Chronic Pain Treatment Guidelines page 18, Specific Anti-Epilepsy Drugs, Neurontin is indicated for diabetic painful neuropathy and post herpetic neuralgia and is considered first line treatment for neuropathic pain. In this case, the exam note from 2/17/15 does not demonstrate evidence neuropathic pain or demonstrate percentage of relief, the duration of relief, increase in function or increased activity. Therefore, medical necessity has not been established, and determination is for non-certification.

Tramadol ER 150mg qty: 90.00: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol Page(s): 93-94.

Decision rationale: Per the CA MTUS Chronic Pain Medical Treatment Guidelines pages 93-94, Tramadol is a synthetic opioid affecting the central nervous system. Tramadol is indicated for moderate to severe pain. Tramadol is considered a second line agent when first line agents such as NSAIDs fail. There is insufficient evidence to support prescribing 90 tablets of Tramadol during the perioperative period following a carpal tunnel release. Therefore, use of Tramadol ER 150 mg quantity 90 is not medically necessary and it is noncertified.

Trazadone 50mg qty: 60.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-depressants for chronic pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain Page(s): 13-15.

Decision rationale: Per the CA MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain page(s): 13-15. Recommended as a first line option for neuropathic pain, and as a possibility for non-neuropathic pain. Tricyclics are generally considered a first-line agent unless they are ineffective, poorly tolerated, or contraindicated. Analgesia generally occurs within a few days to a week, whereas antidepressant effect takes longer to occur. Assessment of treatment efficacy should include not only pain outcomes, but also an evaluation of function, changes in use of other analgesic medication, sleep quality and duration, and psychological assessment. Side effects including excessive sedation (especially that which would affect work performance) should be assessed. It is recommended that these outcome measurements should be initiated at one week of treatment with a recommended trial of at least 4 weeks. As noted, tricyclic antidepressants, like Trazodone, may play a role in treating neuropathic pain. In this case, the exam note of 2/17/15 does not demonstrate evidence of neuropathic pain. From the documents provided, it is unclear whether this patient is experiencing chronic neuropathic pain at this time. There is no clear-cut evidence to recommend Trazodone first line to treat primary insomnia or neuropathic pain in this case. Therefore, determination is for non-certification. The request is not medically necessary.

Flexeril 7.5mg qty: 60.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine Page(s): 41-42.

Decision rationale: According to the CA MTUS, Chronic Pain Medical Treatment Guidelines, Cyclobenzaprine, pages 41-42 "Recommended as an option, using a short course of therapy.

Cyclobenzaprine (Flexeril) is more effective than placebo in the management of back pain; the effect is modest and comes at the price of greater adverse effects. The effect is greatest in the first 4 days of treatment, suggesting that shorter courses may be better. (Browning, 2001) Treatment should be brief. There is also a post-op use. The addition of cyclobenzaprine to other agents is not recommended." In this particular case, the patient has no evidence in the records of 2/17/15 of functional improvement, a quantitative assessment on how this medication helps, percentage of relief lasts, increase in function, or increase in activity. Therefore, chronic usage is not supported by the guidelines. Therefore is not medically necessary and non-certified.

LidoPro cream #1 bottle: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111-112.

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 anti-depressants and anti-convulsants 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." Therefore, the determination is for non-certification. The request is not medically necessary.

Associate surgical service: Physical therapy neck and arms qty: 12.00: Upheld

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

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 16.

Decision rationale: Per the CA MTUS/Post Surgical Treatment Guidelines, Carpal tunnel syndrome, page 16, 3-8 visits over a 3 month period is authorized. In this case, the request of 12 visits exceeds the maximum allowable. In addition the guidelines recommend initial visits be authorized with reassessment. Therefore, the determination is for non-certification. The request is not medically necessary.