

<b>Case Number:</b>	CM15-0087643		
<b>Date Assigned:</b>	05/14/2015	<b>Date of Injury:</b>	09/12/2013
<b>Decision Date:</b>	10/20/2015	<b>UR Denial Date:</b>	04/06/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/07/2015

### 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 47 year old male, who sustained an industrial injury on 09/12/2013. He has reported injury to the bilateral hands/wrists. The diagnoses have included bilateral upper extremity carpal tunnel syndrome; status post right third and fourth finger stenosing tenosynovitis; status post right long trigger finger release with cystic mass and recurrence; status post right ring trigger finger release with residuals; and right index finger stenosing tenosynovitis. Treatments have included medications, diagnostics, bracing, physical therapy. Medications have included Gabapentin. A progress note from the treating physician, dated 02/24/2015, documented a follow-up visit with the injured worker. Currently, the injured worker complains of pain in the right and left hands; is scheduled to attend occupational therapy treatments three times a week; has been performing light duty work; and has continuing right hand/wrist symptoms, but has noted increasing left hand/wrist symptomatology. Objective findings included moderate tenderness to palpation of the A-1 pulley region of right and left long fingers; cystic irregularity affecting the distal end of the A-1 pulley of the right long finger; pain and discomfort to the left long finger with trigger; tenderness to palpation of the volar metocarpophalangeal joint and trigger of the right and left; decreased light touch sensation to the right median nerve; bilaterally positive Phalen's sign and Tinel's sign; and median nerve compression test is positive on the right. The treatment plan has included the request for cold therapy device/motorized cold unit, three times a day; CPM (continuous passive motion) device for finger movement; DVT (deep vein thrombosis) device for the right and left lower extremity; one month trial of a TENS (transcutaneous electrical nerve stimulation) unit, three to four times a

day; Cephalexin (Keflex) 500mg #30, one tablet by mouth every six hours; Ketoralac (Sprix) wound care cream; Ondansetron ODT (Zofran) 4mg #30 with one refill, one tablet by mouth once a day; Lunesta 1mg #30 with one refill, one tablet by mouth at hour of sleep; Cyclobenzaprine 7.5mg #90 with one refill, one tablet by mouth three times a day as needed; and Omeprazole 20mg #30 with one refill, one tablet by mouth once a day as needed.

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

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

#### **Cold therapy device/motorized cold unit, three times a day: 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), 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) Forearm, wrist and hand, Continuous cold therapy.

**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.

#### **CPM device for finger movement: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Blue Cross of California Medical Policy # DME. 00019; Continuous Passive Motion Devices.

**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, CPM.

**Decision rationale:** CA MTUS/ACOEM is silent on the issue of CPM for the hand and fingers. Per the ODG, CPM is "Recommended. Controlled mobilization regimens are widely employed in rehabilitation after flexor tendon repair in the hand. One trial compared continuous passive motion (CPM) with controlled intermittent passive motion (CIPM) and found a significant difference in mean active motion favoring CPM." Per the records provided this patient does not have evidence of a flexor tendon repair or anticipated flexor tendon repair to warrant CPM. Therefore, the request for Continuous Passive Motion is not medically necessary and appropriate for this patient to use post operatively.

#### **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), Knee and Leg 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) Forearm, Wrist and Hand, CPM.

**Decision rationale:** CA MTUS/ACOEM is silent on the issue of CPM for the hand and fingers. Per the ODG, CPM is "Recommended. Controlled mobilization regimens are widely employed in rehabilitation after flexor tendon repair in the hand. One trial compared continuous passive motion (CPM) with controlled intermittent passive motion (CIPM) and found a significant difference in mean active motion favoring CPM." Per the records provided this patient does not have evidence of a flexor tendon repair or anticipated flexor tendon repair to warrant CPM. Therefore, the request for Continuous Passive Motion is not medically necessary and appropriate for this patient to use post operatively.

**One month trial of a TENS unit, three to four times a day:** 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), Forearm, Wrist & Hand Procedure Summary.

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

**Decision rationale:** According to the California MTUS Chronic Pain Medical Treatment Guideline regarding TENS, pages 113-114, chronic pain (transcutaneous electrical nerve stimulation), "Not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration, for neuropathic pain and CRPS II and for CRPS I (with basically no literature to support use). Criteria for the use of TENS: Chronic intractable pain (for the conditions noted above): Documentation of pain of at least three months duration. There is evidence that other appropriate pain modalities have been tried (including medication) and failed. A one-month trial period of the TENS unit should be documented (as an adjunct to ongoing treatment modalities within a functional restoration approach) with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function; rental would be preferred over purchase during this trial. In this case there is insufficient evidence of chronic neuropathic pain from the exam note of 2/24/15 to warrant a TENS unit. There also is no evidence of an evidence-based functional restoration plan. Therefore, the determination is for non-certification. The request is not medically necessary.

**Cephalexin (Keflex) 500mg #30, one tablet by mouth every six hours:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Mosby's Drug Consult.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Bibliography 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 Keflex. In addition, 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.

**Ketorolac (Sprix) wound care cream:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steroidal anti-inflammatory drugs).

**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." Therefore, the request is not medically necessary.

**Ondansetron ODT (Zofran) 4mg #30 with one refill, one tablet by mouth once a day:**  
Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Mosby's Drug Consult.

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

**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 exam note from 2/24/15 does not demonstrate evidence of nausea and vomiting or increased risk for postoperative issues. Therefore, the request is not medically necessary.

**Lunesta 1mg #30 with one refill, one tablet by mouth at hour of sleep:** 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), Pain Procedure Summary.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Mental illness and stress chapter.

**Decision rationale:** CA MTUS/ACOEM is silent on the issue of Lunesta. According to the ODG, Mental Illness and stress chapter, Lunesta is, "Recommend limiting use of hypnotics to three weeks maximum in the first two months of injury only, and discourage use in the chronic phase. While sleeping pills, so-called minor tranquilizers, and anti-anxiety agents are commonly prescribed in chronic pain, pain specialists rarely, if ever, recommend them for long-term use. They can be habit-forming, and they may impair function and memory more than opioid pain relievers." In this case, there is lack of documentation from the exam note of 2/24/15 of insomnia to support Lunesta. Therefore, the request is not medically necessary.

**Cyclobenzaprine 7.5mg #90 with one refill, one tablet by mouth three times a day as needed:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Muscle relaxants (for pain).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Muscle relaxants (for pain).

**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 2/24/15 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.

**Omprazole 20mg #30 with one refill, one tablet by mouth once a day as needed:** 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:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk.

**Decision rationale:** Per the CA MTUS Chronic Pain Medical Treatment Guidelines, page 68, recommendation for Prilosec is for patients with risk factors for gastrointestinal events. The cited records from 2/24/15 do not demonstrate that the patient is at risk for gastrointestinal events. Therefore, the requested Prilosec is not medically necessary.

