MAXIMUS Federal Services

Case Number:	CM13-0021549		
Date Assigned:	11/13/2013	Date of Injury:	09/01/1999
Decision Date:	04/18/2014	UR Denial Date:	08/23/2013
Priority:	Standard	Application Received:	09/10/2013

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. The expert reviewer is Board Certified in Orthopedic Surgeon and Sports Medicine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 patient is a 65-year-old female who reported an injury on 09/01/1999. The mechanism of injury was not stated. The patient is currently diagnosed with cervicogenic disc condition, status post instrumentation and fusion, rotator cuff tear on the right, status post decompression with distal clavicle excision, rotator cuff tear on the left, carpal tunnel syndrome bilaterally, and ulnar nerve entrapment bilaterally. The patient was recently seen by [redacted] on 07/26/2013. The patient was status post fusion along the cervical spine. The patient was also status post bilateral carpal tunnel release on an unknown date. Physical examination revealed positive Tinel's testing along the cubital and carpal tunnel area, tenderness to palpation, aberrant 2 point discrimination along the ulnar distribution of the bilateral hands, and satisfactory motor function of the hands. Treatment recommendations at that time included an ulnar nerve release at the elbow and carpal tunnel release at the wrist on the right side. The patient was also provided with a refill of medications including Prilosec, fentanyl patch, Soma, Percocet, Celebrex, and Cymbalta. It is also noted that the patient underwent an electrodiagnostic study on 01/07/2013, which indicated moderate bilateral carpal tunnel syndrome as a residual and bilateral cubital tunnel syndrome.

IMR ISSUES, DECISIONS AND RATIONALES

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

NEUROPLASTY/TRANSPOSITION, MEDIAN NERVE AT CARPAL TUNNEL: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation ODG-TWC, Page 115, 116, Chronic Pain.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 270-271.

Decision rationale: California MTUS/ACOEM Practice guidelines state referral for hand surgery consultation may be indicated for patients who have red flags of a serious nature, fail to respond to conservative management, and have clear clinical and special study evidence of a lesion. As per the documentation submitted, the patient's electrodiagnostic study obtained on 01/07/2013 does indicate bilateral carpal tunnel syndrome; however, the specific date of the previous carpal tunnel release is unknown. Documentation of an exhaustion of conservative treatment prior to the request for an additional surgical intervention was not provided. The patient does demonstrate positive Tinel's testing and decreased 2 point discrimination upon physical examination. However, there is no indication that this patient has exhausted initial conservative treatment including activity modification, splinting, prescription analgesia, home exercise therapy, or corticosteroid injections. Without evidence of an exhaustion of treatment, the current request cannot be determined a medically appropriate. As such, the request is non-certified.

POLAR CARE TENS UNIT WITH PAD, AND HOT AND COLD WRAP: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation ODG-TWC, Page 115, 116, Chronic Pain.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 270-271.

Decision rationale: As the patient's surgical procedure has not been authorized, the current request for postoperative durable medical equipment is also not medically necessary. Therefore, the request is non-certified.

PRILOSEC 20MG #60: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation ODG-TWC, Page 115, 116, Chronic Pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68-69.

Decision rationale: California MTUS Guidelines state proton pump inhibitors are recommended for patients at intermediate or high risk for gastrointestinal events. Patients with no risk factor and no cardiovascular disease do not require the use of a proton pump inhibitor, even in addition to a nonselective NSAID. There is no indication of cardiovascular disease or increased risk factors for gastrointestinal events. Therefore, the patient does not meet criteria for the requested medication. As such, the request is non-certified.

FENTANYL PATCH 100MCG, 15 PATCHES: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG-TWC, Page 115, 116, Chronic Pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 44, 74-82..

Decision rationale: California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of nonopioid analgesics. Baseline pain and functional assessments should be made. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. The patient has continuously utilized this medication. Despite ongoing use, the patient continues to report constant pain with numbness and activity limitation. Satisfactory response to treatment has not been indicated. Therefore, ongoing use cannot be determined as medically appropriate. As such, the request is non-certified.

FENTANYL 50MCG, 15 PATCHES: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG-TWC, Page 115, 116, Chronic Pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 44, 74-82..

Decision rationale: California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of nonopioid analgesics. Baseline pain and functional assessments should be made. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. The patient has continuously utilized this medication. Despite ongoing use, the patient continues to report constant pain with numbness and activity limitation. Satisfactory response to treatment has not been indicated. Therefore, ongoing use cannot be determined as medically appropriate. As such, the request is non-certified.

PERCOCET 10MG #90: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation ODG-TWC, Page 115, 116, Chronic Pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82..

Decision rationale: California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of nonopioid analgesics. Baseline pain and functional assessments should be made. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. The patient has continuously utilized this medication. Despite ongoing use, the patient continues to report

constant pain with numbness and activity limitation. Satisfactory response to treatment has not been indicated. Therefore, ongoing use cannot be determined as medically appropriate. As such, the request is non-certified.

SOMA 350MG #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation ODG-TWC, Page 115, 116, Chronic Pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63-66, 124..

Decision rationale: California MTUS Guidelines state muscle relaxants are recommended as non-sedating second line options for short-term treatment of acute exacerbations in patients with chronic low back pain. Soma should not be used for longer than 2 to 3 weeks. As per the documentation submitted, the patient has continuously utilized this medication. There is no documentation of palpable muscle spasm or spasticity upon physical examination. Therefore, the patient does not meet criteria for the requested medication. As guidelines do not recommend long-term use of this medication, the current request cannot be determined as medically appropriate. As such, the request is non-certified.

CELEBREX 20MG #30: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation ODG-TWC, Page 115, 116, Chronic Pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68-69.

Decision rationale: California MTUS Guidelines state proton pump inhibitors are recommended for patients at intermediate or high risk for gastrointestinal events. Patients with no risk factor and no cardiovascular disease do not require the use of a proton pump inhibitor, even in addition to a nonselective NSAID. There is no indication of cardiovascular disease or increased risk factors for gastrointestinal events. Therefore, the patient does not meet criteria for the requested medication. As such, the request is non-certified.

CYMBALTA 30MG #90: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation ODG-TWC, Page 115, 116, Chronic Pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 13-16.

Decision rationale: California MTUS Guidelines state antidepressants are recommended as a first line option for neuropathic pain, and as a possibility for nonneuropathic pain. Cymbalta is

FDA approved for anxiety, depression, diabetic neuropathy, and fibromyalgia. As per the documentation submitted, the patient utilizes Cymbalta for depression; however, there is no documentation of objective functional improvement despite ongoing use of this medication. There is no evidence of a psychiatric examination. Based on the clinical information received, the request is non-certified.

AMOXICILLIN 875MG #20: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation ODG-TWC, Page 115, 116, Chronic Pain.

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, AMOXICILLIN (AMOXILï¿½)

Decision rationale: Official Disability Guidelines state amoxicillin is recommended as first line treatment for cellulitis and skin and soft tissue infections. The patient does not appear to meet criteria for the requested medication. Therefore, the request is non-certified.

ZOFRAN 8MG #20: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation ODG-TWC, Page 115, 116, Chronic Pain.

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: Official Disability Guidelines state Zofran is not recommended for nausea and vomiting secondary to chronic opioid use. Zofran has been FDA approved for nausea and vomiting secondary to chemotherapy and radiation treatment, and has also been approved for postoperative use. The patient does not appear to meet criteria for the requested medication. Therefore, the request is non-certified.

NEURONTIN 600MG #180: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation ODG-TWC, Page 115, 116, Chronic Pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 16-18.

Decision rationale: California MTUS Guidelines state antiepilepsy drugs are recommended for neuropathic pain. Neurontin has been shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia, and has also been considered as a first line treatment for neuropathic pain. As per the documentation submitted, there is no evidence of this patient's

current utilization of this medication. Therefore, the current request cannot be determined as medically appropriate. As such, the request is non-certified.