

Case Number:	CM13-0023839		
Date Assigned:	03/26/2014	Date of Injury:	08/25/2003
Decision Date:	04/28/2014	UR Denial Date:	09/06/2013
Priority:	Standard	Application Received:	09/12/2013

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 Occupational 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 an employee of [REDACTED] System and has submitted a claim for Thoracic Outlet Syndrome, bilateral; Flexor Tendinitis, left wrist; and Sacrococcygeal neuropathy associated with an industrial injury date of 08/25/2003. Treatment to date has included botox injections, radiofrequency ablation on 05/15/13, physical and occupational therapy, acupuncture, aqua therapy, shoulder immobilizer, wrist brace, oral and topical medications. Medical records from 2011 to 2013 were reviewed. The most recent progress report available for review is dated 08/24/2013 stating that patient was experiencing more paresthesia and pain graded 7-9/10 at bilateral upper extremities radiating into the wrists and fingers worsened by quick movements. There was likewise sharp pain at the right anterior chest and shoulder. Patient was not able to shower or groom herself independently. She was unable to drive a car due to pain. Physical examination showed that her right shoulder was lower by 2 cm compared to the left shoulder. There was presence of pain at end-range of neck extension. Neck lateral bending on both sides was limited to 30 degrees. She had limited shoulder abduction at 150 degrees bilaterally, right shoulder external rotation at 40 degrees, and left shoulder external rotation at 55 degrees due to presence of pain. She had equal grip strength of 10 kilograms. Special tests for thoracic outlet syndrome performed include retroclavicular Spurling test showing positive symptoms at right, and loss of pulse at left. Wright's hyperabduction test showed positive symptoms at 130 degrees of right shoulder flexion with loss of pulse at 40 degrees of left shoulder flexion. Halstead maneuver was positive bilaterally. Both Adson's test and cervical Spurling test were negative bilaterally. Objective findings for the left wrist include tenderness at flexor carpi radialis and flexor carpi ulnaris, left with presence of pain during resisted left wrist flexion. There was bilateral intrinsic hand atrophy, moderate with intrinsic muscle weakness. There was hyposthesia at both first digits, right middle finger, left index

finger and left ring finger while hypesthesia was noted at both fifth digits. The coccyx and sacrum were tender. An MRI of the right brachial plexus, dated 08/09/2011, documented moderate right subclavian artery narrowing to 3-4 mm in the costoclavicular space; right costoclavicular space narrowed with arms up; severe subclavian vein narrowing on the right in the costoclavicular space to 2 mm and lateral interscalene space to 2-3mm; severe left subclavian artery narrowing to 2 mm in the costoclavicular space; left costoclavicular space narrowed with arms up; and severe subclavian vein narrowing on the left in the costoclavicular space to 2 mm. MRI of the right shoulder, dated 01/04/2011, showed mild degree of fluid within the shoulder joint which may be nonspecific but could indicate synovitis, or a small effusion, anterior capsulitis and sprain, small amount of fluid in the subscapularis bursa, appearance suspicious for superior labral tear, small focus of tendinosis / partial tear of the supraspinatus tendon, no full-thickness supraspinatus or other rotator cuff tendon tear, no abnormality was documented with respect to the biceps tendon, and possible mild degree of subacromial-subdeltoid bursitis. Current medications include BCKLL (baclofen, cyclobenzaprine, ketoprofen, ketorolac, and lidocaine) cream, alprazolam, Colace, Magnesium, oxycodone, Zofran ODT, Nexium, Frova and Treximet.

IMR ISSUES, DECISIONS AND RATIONALES

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

BOTOX INJECTIONS FOR BILATERAL THORACIC OUTLET SYNDROME (TOS) & MIGRAINES: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 25-26.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines section on Botulinum toxin Page(s): 25-26.

Decision rationale: As stated in pages 25-26 of the MTUS Chronic Pain Guidelines, Botulinum toxin (Botox; Myobloc) is not generally recommended for chronic pain disorders such as tension-type headache, migraine headache, fibromyositis, chronic neck pain, myofascial pain syndrome and trigger point injections. In this case, the request is for Botox injections for bilateral TOS and migraine which are not recommended by the MTUS Chronic Pain Guidelines. Furthermore, a similar request was already certified on 08/23/2013; however, there was no documentation stating its outcome. Therefore, the request for Botox injections for bilateral TOS and migraine is not medically necessary and appropriate.

PHYSICAL THERAPY FOR BILATERAL THORACIC OUTLET SYNDROME 2 X 8 WEEKS FOLLOWING BOTOX INJECTIONS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines section on Physical Medicine Page(s): 98-99.

Decision rationale: As stated on pages 98-99 of the MTUS Chronic Pain Guidelines, physical medicine is recommended and should be tapered and transition into a self-directed home program. In this case, the patient already had 19 treatment sessions to date and the patient should be well-versed on independent exercises by now. Furthermore, since the request for botox injections was not certified, it is also reasonable to non-certify the physical therapy sessions following the botox injections requested. Therefore, the request for physical therapy for bilateral thoracic outlet syndrome 2 x 8 weeks following botox injections is not medically necessary and appropriate.

CONTINUED ACUPUNCTURE 2X8 WEEKS FOR PAIN AND MEDICATION

INDUCED NAUSEA: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: As stated in pages 8-9 of MTUS Acupuncture Medical Treatment Guidelines, acupuncture may be used as an option when pain medication is reduced or not tolerated, it may be used as an adjunct to physical rehabilitation or to hasten functional recovery. It can be used to reduce pain, reduce inflammation, increase blood flow, increase range of motion, decrease the side effect of medication-induced nausea, promote relaxation in an anxious patient, and reduce muscle spasm. The frequency and duration to produce functional improvement is 3 - 6 treatments, at a frequency of 1 - 3 times per week, and duration of 1 - 2 months. It may be extended if functional improvement is documented. In this case, the patient was noted to have had 38 sessions of acupuncture from 01/04/2013 to 06/28/2013. There was no documentation stating the pain reduction, functional improvement or decreased medication-induced nausea associated with the use of acupuncture. Therefore, the request for continued acupuncture 2 x 8 weeks for pain and medication-induced nausea is not medically necessary and appropriate.

OCCUPATIONAL THERAPY 1-2 TIMES A WEEK X 8 WEEKS FOR LEFT WRIST

FLEXOR TENDINITIS FLARE-UP: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines section on Physical Medicine Page(s): 98-99.

Decision rationale: As stated on pages 98-99 of the MTUS Chronic Pain Guidelines, physical medicine is recommended and should be tapered and transition into a self-directed home program. In this case, the patient was documented to be having occupational therapy from 01/11/2013 to 05/28/2013. Medical records submitted for review did not show any documentation of functional improvement associated to occupational therapy. The patient is

expected to be well-versed in a home program at this time. Therefore, the request for occupational therapy 1-2 times a week x 8 weeks for left wrist flexor tendinitis flare-up is not medically necessary and appropriate.

TRANSPORTATION (LYING DOWN) TO THERAPY LOCATIONS DUE TO TOS:

Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Knee and Leg

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg

Decision rationale: ODG recommend medically-necessary transportation to appointments in the same community for patients with disabilities preventing them from self-transport. In this case, there was no documentation stating that the patient cannot ride public or private vehicles to therapy locations due to TOS. The medical necessity for a transportation (lying down) was not established. Therefore, the request for transportation (lying down) to therapy locations due to TOS is not medically necessary and appropriate.

COMPOUNDED TOPICAL CREAM - BACLOFEN, CYCLOBENZAPRINE, KETOPROFEN, KETOROLAC, LIDOCAINE: Upheld

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

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

Decision rationale: Pages 111-113 of MTUS Chronic Pain Guidelines state that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. The mechanism of action of Baclofen is blockade of the pre- and post-synaptic GABA receptors. There is no peer-reviewed literature to support the use of topical baclofen. Ketoprofen is an NSAID that is not currently FDA-approved for a topical application. Ketorolac is not indicated for minor or chronic painful conditions. Lidocaine topical is only approved as a dermal patch formulation. Cyclobenzaprine is a skeletal muscle relaxant and a central nervous system antidepressant. However, the addition of cyclobenzaprine to other agents is not recommended. The guidelines stated that any compounded product that contains at least one drug (drug class) that is not recommended is not recommended. In this case, the documentation submitted for review was insufficient to indicate that the patient has failed a trial of oral pain medications prior to proceeding with the use of topical analgesic. There was also no discussion concerning the prescription of unsupported medications based on guidelines. The request for compounded topical cream - baclofen, cyclobenzaprine, ketoprofen, ketorolac, lidocaine is therefore not medically necessary and appropriate.

TRIAL OF SAM-e 800 MG FOR NEUROPATHIC PAIN: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation
<http://www.ncbi.nlm.nih.gov/pubmed/20595412>

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS.
Decision based on Non-MTUS Citation FDA

Decision rationale: The ACOEM, MTUS Chronic Pain and Official Disability Guidelines do not address the use of SAM-e for neuropathic pain. The Food and Drug Administration states that specific requirements for the safety or appropriate use of medical foods have not yet been established. In this case, there is no rationale or indication provided necessitating the use of S-adenosyl methionine (SAM-e). Therefore, the request for SAM-e 800mg for neuropathic pain is not medically necessary and appropriate.