MAXIMUS Federal Services

Case Number:	CM13-0024279		
Date Assigned:	03/14/2014	Date of Injury:	11/08/2002
Decision Date:	09/15/2014	UR Denial Date:	08/29/2013
Priority:	Standard	Application Received:	09/16/2013

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 Family Medicine, has a subspecialty in Clinical Informatics and is licensed to practice in Pennsylvania. 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:

This worker sustained an injury on November 8, 2002. She had reached maximal medical improvement in relationship to those injuries by May 3, 2004. According to the primary treating physicians progress report on June 26, 2013 her symptoms included pain in the neck and upper back radiating to the right upper extremity, left wrist pain, triggering of the left third digit, paresthesias in the upper and lower extremities, and bilateral knee pain secondary to degenerative osteoarthritis. An MRI of the cervical spine in 2005 revealed diffuse disc bulge at C3-4, C5-6 and C6-7 with narrowing of the neural foramina. An EMG/NCV in August of 2012 revealed normal EMG of the cervical spine and upper extremities and abnormal NCV demonstrating bilateral carpal tunnel syndrome. An MRI of the cervical spine in December 2012 showed disc protrusion affecting the thecal sac at multiple levels. An EMG/NCV of the lower extremities in December 2013 was normal. An MRI of the left knee in 2007 revealed meniscal degeneration and osteoarthritic changes. Her diagnoses on June 26, 2013 included multilevel cervical disc protrusion with bilateral neural foraminal narrowing, spondylolisthesis C4-5 and C5-6, degenerative disc disease of the cervical spine, carpal tunnel syndrome on the left, trigger finger of the third left finger, neck pain syndrome with multilevel disc bulge and bilateral neural foraminal narrowing and radiculopathy of the right upper extremity, shoulder tendinitis on the right and shoulder impingement syndrome, carpal tunnel syndrome on the right, chronic low back syndrome with radiculopathy in both lower extremities, left knee strain and degenerative joint disease, anterior chest wall syndrome, history of hyperacidity, anxiety and depression, and stress related insomnia. The treatment plan on that date included trigger point injection to the left third trigger finger; random blood sugar determination which was 85 mg/dL; medications including Omeprazole 20 mg twice a day for GI problems, #60; Neurontin 300 mg every 8 hours for neuropathy, #60; Cymbalta 30 mg once daily for depression, #30; Lidocaine patches 5% to

be applied on areas with pain, #30; Capsaicin gel 60 g for pain, apply twice a day; acupuncture to the neck and right sided upper back 2 times a week for 4 weeks; continue chiropractic evaluation and treatment to the neck and upper back once a week for 4 weeks; continue using the IF 4 unit at home for pain symptoms of the neck and back.

IMR ISSUES, DECISIONS AND RATIONALES

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

TRIGGER POINT INJECTION TO THE LEFT 3RD FINGER: 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 ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 265.

Decision rationale: According to the MTUS/ACOEM guidelines "trigger finger, if significantly symptomatic, is probably best treated with a cortisone/anesthetic injection at first encounter, with hand surgery referral if symptoms persist after 2 injections. The presence of trigger finger in itself is not an indication for injection but significant symptoms associated with the trigger finger would be. In this case there is no documentation of significant symptoms and the exam provides no details other than that there was triggering of the third digit of the left hand. Therefore, injection cannot be determined to be medically necessary.

RANDOM BLOOD SUGAR 85/DL: 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), Diabetes Chapter, Diabetes Screening.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Diabetes, Diabetes Screening and Glucose Monitoring.

Decision rationale: There is no indication in the medical record that this worker had diabetes to require glucose monitoring. There was no mention of risk factors that would require screening.

OMEPRAZOLE 20MG #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI SYMPTOMS, CARDIOVASCULAR RISK Page(s): 68.

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

Decision rationale: Omeprazole might be indicated if this worker was taking an NSAID and at risk for gastrointestinal events. The medical record does not indicate she was taking an NSAID or at risk for gastrointestinal events. History of hyperacidity does not indicate a current problem such as peptic ulcer disease or esophageal reflux to support the need for a proton pump inhibitor.

NEURONTIN 300MG #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines GABAPENTIN (NEURONTIN) Page(s): 18.

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

Decision rationale: Neurontin is recommended for the treatment of neuropathic pain. However, there is insufficient documentation in the record to substantiate that this worker's pain was neuropathic in nature. A statement that pain in the neck and upper back radiating into the right upper extremity is non specific and does not suggest neuropathic pain. Furthermore, EMG of the cervical spine and upper extremities in 2012 was normal. NCV study in 2012 did reveal evidence of bilateral moderate carpal tunnel syndrome but a statement of complaint of left wrist pain is insufficient to substantiate neuropathic pain.

CYMBALTA 30MG #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ANTIDEPRESSANTS FOR CHRONIC PAIN Page(s): 13-16.

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

Decision rationale: Cymbalta is approved for anxiety, depression, diabetic neuropathy and fibromyalgia. It is used off label for neuropathic pain and radiculopathy. The medical record reported a subjective complaint of irritability, anxiety and depression but this is insufficient to substantiate a diagnosis of anxiety or depression. There is no indication the worker had diabetic neuropathy or fibromyalgia. There was also insufficient documentation to substantiate that her pain complaints were related to neuropathic pain or radiculopathy. A statement that pain in the neck and upper back radiating into the right upper extremity is non specific and does not suggest neuropathic pain. Furthermore, EMG of the cervical spine and upper extremities in 2012 was normal. NCV study in 2012 did reveal evidence of bilateral moderate carpal tunnel syndrome but a statement of complaint of left wrist pain is insufficient to substantiate neuropathic pain.

LIDOCAINE PATCHES 5% #30: 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 Page(s): 111-113.

Decision rationale: Topical Lidocaine is recommended for neuropathic pain but not for non-neuropathic pain. A statement that pain in the neck and upper back radiating into the right upper extremity is non specific and does not suggest neuropathic pain. Furthermore, EMG of the cervical spine and upper extremities in 2012 was normal. NCV study in 2012 did reveal evidence of bilateral moderate carpal tunnel syndrome but a statement of complaint of left wrist pain is insufficient to substantiate neuropathic pain.

ELECTRODE PATCHES FOR IF4 UNIT: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines INTERFERENTIAL CURRENT STIMULATION Page(s): 118-119.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 118-119.

Decision rationale: Interferential current stimulation is not recommended as an isolated intervention. It may be effective in conjunction with recommended treatments, including return to work, exercise and medications. Interferential current stimulation is possibly appropriate if at least one of the following conditions are met: 1) pain is ineffectively controlled due to diminished effectiveness of medications, 2) pain is ineffectively controlled with medications due to side effects, 3) history of substance abuse, 4) significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment, 5) unresponsive to conservative measures such as repositioning, heat/ice, etc. If one of these criteria is met, then a one-month trial may be appropriate to determine if the treatment will be beneficial. Documentation of increased functional improvement, less reported pain and evidence of medication reduction in response to interferential current stimulation is required to substantiate the need for continued interferential current stimulation beyond a one-month trial period. In this case criteria have not been met to substantiate the medical necessity of continued treatment with interferential current stimulation and therefore the electrode patches are not medically necessary.

CHIROPRACTIC EVALUATION FOR THE NECK AND UPPER BACK 1 X 4: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MANUAL THERAPY AND MANIPULATION Page(s): 58.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58.

Decision rationale: Manual therapy and manipulation is recommended for chronic pain caused by musculoskeletal conditions. Maximum duration is typically 8 weeks. The duration greater than 8 weeks may be indicated if manipulation has been helpful in improving function, decreasing pain and improving quality of life. In those cases treatment may be continued once every other week until the patient has reached a plateau. The medical record available for review

states this worker reported getting benefit from the acupuncture and chiropractic treatment but there was no documentation of how long she had been receiving treatment and what benefit she was receiving. There was no documentation of improved function, decreased pain or improved quality of life. Therefore, chiropractic cannot be determined to be medically necessary.

CHIROPRACTIC TREATMENT TO NECK AND BACK 1 X 4: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MANUAL THERAPY AND MANIPULATION Page(s): 58.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58.

Decision rationale: Manual therapy and manipulation is recommended for chronic pain caused by musculoskeletal conditions. Maximum duration is typically 8 weeks. The duration greater than 8 weeks may be indicated if manipulation has been helpful in improving function, decreasing pain and improving quality of life. In those cases treatment may be continued once every other week until the patient has reached a plateau. The medical record available for review states this worker reported getting benefit from the acupuncture and chiropractic treatment but there was no documentation of how long she had been receiving treatment and what benefit she was receiving. There was no documentation of improved function, decreased pain or improved quality of life. Therefore, chiropractic cannot be determined to be medically necessary.

IF4 UNIT FOR THE NECK AND BACK: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines INTERFERENTIAL CURRENT STIMULATION Page(s): 118-119.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 118-119.

Decision rationale: Interferential current stimulation is not recommended as an isolated intervention. It may be effective in conjunction with recommended treatments, including return to work, exercise and medications. Interferential current stimulation is possibly appropriate if at least one of the following conditions are met: 1) pain is ineffectively controlled due to diminished effectiveness of medications, 2) pain is ineffectively controlled with medications due to side effects, 3) history of substance abuse, 4) significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment, 5) unresponsive to conservative measures such as repositioning, heat/ice, etc. If one of these criteria is met, then a one-month trial may be appropriate to determine if the treatment will be beneficial. Documentation of increased functional improvement, less reported pain and evidence of medication reduction in response to interferential current stimulation is required to substantiate the need for continued interferential current stimulation beyond a one-month trial period. In this case criteria have not been met to substantiate the medical necessity of continued treatment with interferential current stimulation.

CAPSAICIN GEL 60GM: 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 Page(s): 111-113.

Decision rationale: Capsaicins are recommended only as an option in patients who have not responded or are intolerant to other treatments. There is no indication that a formulation greater than 0.025% would provide any further efficacy. The medical record available for review does not indicate where the gel was to be applied, what pain it was being directed towards, and if other treatments for that particular pain had already been tried. Furthermore the specific formulation of Capsaicin gel being prescribed was not provided and therefore medical necessity cannot be determined.

ACUPUNCTURE FOR THE NECK AND UPPER BACK 2 X 4: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: Functional improvement is expected in 3-6 acupuncture treatments. Frequency of acupuncture should be one to 3 times per week with an optimal duration of one to 2 months. Acupuncture may be extended longer than this if functional improvement is documented. The medical record available for review indicates this worker had already been receiving acupuncture but does not indicate for how long or how many treatments. Although the worker does report receiving benefit from acupuncture there is no documentation of functional improvement. Therefore acupuncture cannot be determined to be medically necessary.

LIDOCAINE 1%: 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 ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 265.

Decision rationale: According to the MTUS/ACOEM guidelines "trigger finger, if significantly symptomatic, is probably best treated with a cortisone/anesthetic injection at first encounter, with hand surgery referral if symptoms persist after 2 injections. The presence of trigger finger in itself is not an indication for injection but significant symptoms associated with the trigger finger would be. In this case there is no documentation of significant symptoms and the exam provides no details other than that there was triggering of the third digit of the left hand. Therefore,

injection cannot be determined to be medically necessary and consequently Lidocaine to be used for injection is not medically necessary.

CELESTONE: 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 ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 265.

Decision rationale: According to the MTUS/ACOEM guidelines "trigger finger, if significantly symptomatic, is probably best treated with a cortisone/anesthetic injection at first encounter, with hand surgery referral if symptoms persist after 2 injections. The presence of trigger finger in itself is not an indication for injection but significant symptoms associated with the trigger finger would be. In this case there is no documentation of significant symptoms and the exam provides no details other than that there was triggering of the third digit of the left hand. Therefore, injection cannot be determined to be medically necessary and consequently Celestone to be used for injection is not medically necessary.

SURGICAL TRAY: 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 ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 265.

Decision rationale: According to the MTUS/ACOEM guidelines "trigger finger, if significantly symptomatic, is probably best treated with a cortisone/anesthetic injection at first encounter, with hand surgery referral if symptoms persist after 2 injections. The presence of trigger finger in itself is not an indication for injection but significant symptoms associated with the trigger finger would be. In this case there is no documentation of significant symptoms and the exam provides no details other than that there was triggering of the third digit of the left hand. Therefore, injection cannot be determined to be medically necessary and consequently a surgical tray to be used for injection is not medically necessary.