

Case Number:	CM13-0032731		
Date Assigned:	06/02/2014	Date of Injury:	03/01/2004
Decision Date:	08/12/2014	UR Denial Date:	10/02/2013
Priority:	Standard	Application Received:	10/09/2013

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 Physical Medicine & Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Texas and Oklahoma. 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 injured worker is a 45-year-old female who reported an injury on 03/01/2004. The mechanism of injury was not provided. On 05/09/2014, the injured worker presented with neck pain radiating down the upper left extremity associated with cervicogenic headaches. She also reported right shoulder pain aggravated by overhead activity. Upon examination of the cervical spine, there was tenderness to palpation bilaterally over the cervical musculature with increased muscle rigidity. There were numerous trigger points that were palpable and tender throughout the cervical paraspinal muscles. There was also tenderness along the left side of her neck and trapezial healed scar. The diagnoses were cervical spine myoligamentous injury, bilateral shoulder overuse syndrome, left greater than right, bilateral carpal tunnel syndrome, left greater than right, status post left carpal tunnel release on 01/26/2007, cervicogenic headaches, right elbow medial epicondylitis with subluxation of the ulnar nerve, and medication-induced gastritis. Prior therapy included medication, surgery, and therapy. The provider recommended a drug test, trigger point injection, Lidoderm patch, topical analgesia, chiropractic care, and home electrical TENS unit. The provider's rationale for the injections was to maintain function and help decrease medication use, chiropractic would be beneficial in alleviating pain and spasms, and chiropractic care has been very beneficial in alleviating pain and spasms across the neck and improving range of motion, strength, and overall endurance. The Request for Authorization Form was not included in the medical documents for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

RETROSPECTIVE REQUEST FOR DRUG TEST DOS:9/13/13: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines URINE DRUG SCREEN Page(s): 43.

Decision rationale: The retrospective request for drug test dated 09/13/2013 is not medically necessary. The California MTUS Guidelines recommend a urine drug test as an option to assess for the use or presence of illegal drugs. It may also be used in conjunction with therapeutic trial of opioids, for ongoing management, and as a screening for misuse and addiction. The documentation provided did not indicate the injured worker displayed any aberrant behaviors, drug seeking behavior, or whether the injured worker was suspected of illegal drug use. It was unclear when the last urine drug screen was performed. As such, the request is not medically necessary.

RETROSPECTIVE REQUEST FOR TRIGGER POINT INJECTIONS (#4) WITH 10CC OF 0.25% BUPIVICAINE DOS:9/13/13: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TRIGGER POINT INJECTIONS Page(s): 122.

Decision rationale: The retrospective request for trigger point injections #4 with 10 cc of 0.25 bupivacaine, date of service 09/13/2013, is not medically necessary. The California MTUS Guidelines recommend trigger point injections for myofascial pain syndrome as indicated with limited lasting value, and they are not recommended for radicular pain. Trigger point injections with local anesthetic may be recommended for treatment of chronic low back or neck pain with myofascial pain syndrome when the following criteria are met: documentation of circumscribed trigger point injections with evidence upon palpation of a twitch response, as well as referred pain, symptoms persisting more than 3 months, conservative care therapies failed to control pain, radiculopathy not present, no more than 3 injections to 4 injections per session, no repeat injections without a 50% relief of pain obtained for 6 weeks after the injection and documented evidence of functional improvement, and frequency should not be at an interval less than 2 months. There is a lack of evidence in the documentation that medical management therapy, such as ongoing stretching, physical therapy, and NSAIDs, have failed to control pain. Additionally, there was no mention of a twitch response upon palpation during the physical examination, and there was no documentation of provocative testing indicating pathology to warrant trigger point injections. Additionally, the provider's request does not indicate the site of the trigger point injections in the request as submitted. As such, the request is not medically necessary.

LIDODERM PATCH 5%: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines LIDODERM (LIDOCAINE PATCH) Page(s): 56-57.

Decision rationale: The request for Lidoderm patch 5% is not medically necessary. The California MTUS states that topical Lidocaine may be recommended for localized peripheral pain after there has been evidence of a first line therapy such as a tricyclic or SNRI antidepressant or AED such as Gabapentin or Lyrica. This is not a first line treatment and it is only FDA approved for postherpetic neuralgia. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than postherpetic neuralgia. The included documentation does not indicate that the injured worker has a diagnosis that is congruent with the guideline recommendation of Lidoderm patch. Additionally, the provider's request does not indicate the quantity of patches or the frequency of the patch in the request as submitted. As such, the request is not medically necessary.

CONTINUED USE OF DENDRACIN TOPICAL ANALGESIC CREAM: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL ANALGESICS Page(s): 111.

Decision rationale: The request for continued use of Dendracin topical analgesic cream is not medically necessary. The California MTUS state that transdermal compounds are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least 1 drug that is not recommended is not recommended. The guidelines note that capsaicin is indicated for injured workers who are intolerant to or have not responded to other treatments. The provided documentation lacks evidence of the injured worker being intolerant to or having not responded to other treatments. The provider's request for Dendracin topical cream does not indicate the dose, frequency, or quantity of the cream in the request as submitted. There is also no mention of the site for which the cream was intended in the request. As such, the request is not medically necessary.

CHIROPRACTIC TREATMENT LIMITED TO THE NECK, LEFT SHOULDER AND BILATERAL WRISTS ONLY: Upheld

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

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

Decision rationale: The request for chiropractic treatment limited to the neck, left shoulder, and bilateral wrists only is not medically necessary. The California MTUS Guidelines state that chiropractic care for chronic pain if caused by musculoskeletal conditions is recommended. The intended goal or effect of manual medicine is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the injured worker's therapeutic exercise program and return to productive activities. The guidelines recommend a trial of 6 visits over 2 weeks, and with evidence of objective functional improvement, a total of up to 18 visits over 6 weeks to 8 weeks. The provider's request for chiropractic treatment does not indicate the amount of chiropractic treatment being requested or the frequency of the chiropractic visits. As such, the request is not medically necessary.

HOME ELECTRICAL STIM/TENS UNIT: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CRITERIA FOR USE OF TENS Page(s): 116.

Decision rationale: The request for home electrical stim/TENS unit is not medically necessary. The California MTUS Guidelines do not recommend a TENS unit as a primary treatment modality. A 1 month home-based TENS trial may be considered as a non-invasive conservative option, if used as an adjunct to a program of evidence based functional restoration. The results of studies are inconclusive; the published trials do not provide information on stimulation parameters which are most likely to provide optimum pain relief, nor do they answer the question about long term effectiveness. The included medical documentation does not indicate if the injured worker underwent an adequate TENS trial. The provider's request also does not specify whether the request is for the purchase or the rental of a TENS unit. The site at which the TENS unit was recommended for is also not included in the request. As such, the request is not medically necessary.