

Case Number:	CM13-0039315		
Date Assigned:	12/18/2013	Date of Injury:	05/26/2011
Decision Date:	03/17/2014	UR Denial Date:	08/02/2013
Priority:	Standard	Application Received:	10/04/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Anesthesia, has a subspecialty in both Acupuncture and Pain 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 physician 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 48-year-old injured worker with date of injury 5/26/11. Review of the records indicates that the patient was being treated for chronic wrist, right shoulder, and cervical spine pain. Per 7/12/13 report, the injured worker complained of constant bilateral wrist, hand, and forearm pain, on and off right shoulder and neck pain, as well as headaches. She also had complaints of tingling and numbness of the hands and fingertips, spasm of the neck and right shoulder, and muscle weakness of both wrists and hands. The pain was reportedly disturbing her sleep. Physical examination of the cervical spine revealed midline tenderness, facet tenderness at C2-C3 and C5-6, and painful range of motion. Examination of the right shoulder revealed tenderness over the anterior aspect and limited range of motion. Wrist exam revealed positive carpal tunnel compression, Tinel's sign, and Phalen's test bilaterally. MRI of the right shoulder dated 5/8/12 showed supraspinatus and infraspinatus tendinopathy, acromioclavicular joint arthropathy. MRI of the left shoulder dated 5/8/12 showed supraspinatus and infraspinatus tendinopathy, fraying/degeneration of superior glenoid labrum subacromial/subdeltoid bursal effusion, acromioclavicular joint arthropathy. EMG/NCS of the upper extremity 7/11/13 showed mild carpal tunnel syndrome on the left. The injured worker was refractory to medications. She had also been treated with chiropractic physical therapy without benefit and has a history of right carpal tunnel release in November of 2012 with adverse outcomes. The date of UR decision was 8/2/13.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ultracin, 120 count: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 60,111-112.

Decision rationale: Ultracin contains methyl salicylate, capsaicin, and menthol. Capsaicin may have an indication for pain in this context. Per MTUS p 112 "Indications: There are positive randomized studies with capsaicin cream in patients with osteoarthritis, fibromyalgia, and chronic non-specific back pain, but it should be considered experimental in very high doses. Although topical capsaicin has moderate to poor efficacy, it may be particularly useful (alone or in conjunction with other modalities) in patients whose pain has not been controlled successfully with conventional therapy." While the injured worker does not have glenohumeral osteoarthritis, the MRI of the shoulder does demonstrate acromioclavicular arthropathy. Methyl salicylate may have an indication for chronic pain in this context. According to the Chronic Pain Medical Treatment Guidelines, "Recommended. Topical salicylate (e.g., Ben-Gay, methyl salicylate) is significantly better than placebo in chronic pain. (Mason-BMJ, 2004)." According to the Chronic Pain Medical Treatment Guidelines, any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Regarding the use of multiple medications, the Chronic Pain Medical Treatment Guidelines states "Only one medication should be given at a time, and interventions that are active and passive should remain unchanged at the time of the medication change. A trial should be given for each individual medication. Analgesic medications should show effects within 1 to 3 days, and the analgesic effect of antidepressants should occur within 1 week. A record of pain and function with the medication should be recorded. The recent AHRQ review of comparative effectiveness and safety of analgesics for osteoarthritis concluded that each of the analgesics was associated with a unique set of benefits and risks, and no currently available analgesic was identified as offering a clear overall advantage compared with the others." Therefore, it would be optimal to trial each medication individually. The request for Ultracin, 120 count, is not medically necessary or appropriate.

Vicodin 5/500mg, 30 count: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 76.

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines regarding therapeutic trial of opioids, questions to ask prior to starting therapy include "(a) Are there reasonable alternatives to treatment, and have these been tried? (b) Is the patient likely to improve? (c) Is there likelihood of abuse or an adverse outcome?" Review of the submitted records indicates that the injured worker has previously failed treatment with Tramadol, Tramadol ER, Naprosyn, Neurontin, Lodine and Tylenol #3 (which she felt was too strong). The

injured worker was provided prescription for Neurontin 600 mg BID #60 and Lodine 400 mg BID #60 on 12/6/13. According to the Chronic Pain Medical Treatment Guidelines, "(b) A therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics.", the failure of the aforementioned treatment should be established before the initiation of opioid therapy. The records submitted for review do not address the efficacy of Neurontin and Lodine. The request for Vicodin 5/500mg, 30 count, is not medically necessary or appropriate.

One diagnostic right and left wrist median nerve block, with carpal tunnel steroid injection as diagnostic and therapeutic injection: 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 ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 272. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Carpal Tunnel Syndrome Chapter, Injections Section

Decision rationale: According to the Forearm, Wrist, and Hand Complaints Chapter of the ACOEM Practice Guidelines, Injection of corticosteroids into carpal tunnel in mild or moderate cases of CTS (carpal tunnel surgery) after trial of splinting and medication is recommended. It is noted that the injured worker had already undergone bilateral wrist injections for CTS with no improvement. According to the ODG guidelines "a single injection is recommended. Additional injections are only recommended on a case-to-case basis. Repeat injections are only recommended if there is evidence that a patient who has responded to a first injection is unable to undertake a more definitive surgical procedure at that time." However, I respectfully disagree with the treating physician who stated "The patient's diagnostic injections are absolutely essential in planning future treatment and also to prevent unnecessary treatment to other body parts since carpal tunnel syndrome can cause referred pain to upper extremity, shoulder and neck." Repeat injections are not needed for diagnostic purpose, the diagnostic assessment can be inferred from the results of the first injection. The request for one diagnostic right and left wrist median nerve block with carpal tunnel steroid injection as diagnostic and therapeutic injection is not medically necessary or appropriate.

One right shoulder subacromial steroid injection with acromioclavicular joint injection with suprascapular nerve block: Overturned

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: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter, Steroid Injections Section.

Decision rationale: According to the ODG, steroid injections are "Recommended as indicated below, up to three injections. Steroid injections compared to physical therapy seem to have better

initial but worse long-term outcomes." For impingement syndrome: " In a large randomized trial on the management of subacromial impingement syndrome by physical therapists there was no significant difference in the score on the shoulder pain and disability index at three months in participants who received a combination of injection and exercise compared with those who received exercise therapy alone, but significantly earlier improvements in pain and functional disability at one and six weeks were seen in the group given corticosteroid injection. If early pain relief is a priority, then adding local steroid injection to a course of physical therapy might be a good option." According to the ODG suprascapular nerve block is recommended, "Suprascapular nerve block is a safe and efficacious treatment for shoulder pain in degenerative disease and/or arthritis. It improves pain, disability, and range of movement at the shoulder compared with placebo. The use of bupivacaine suprascapular nerve blocks was effective in reducing the pain of frozen shoulder at one month, but not range of motion. Suprascapular nerve blocks have produced faster and more complete resolution of pain and restoration of range of movement than a series of intra-articular injections. (Dahan, 2000) (Jones, 1999) (Shanahan, 2003) (Shanahan, 2004) According to this systematic review, there was moderate evidence for the effectiveness of suprascapular nerve block compared with acupuncture, placebo, or steroid injections for pain relief." The request for one right shoulder subacromial steroid injection with acromioclavicular joint injection with suprascapular nerve block is medically necessary and appropriate.