

<b>Case Number:</b>	CM13-0066137		
<b>Date Assigned:</b>	01/15/2014	<b>Date of Injury:</b>	06/04/1998
<b>Decision Date:</b>	04/22/2014	<b>UR Denial Date:</b>	11/20/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/16/2013

### 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 Internal Medicine and Emergency Medicine, and is licensed to practice in Florida. 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:

This patient is a 57 year-old with a date of injury of 06/04/98. A progress report associated with the request for services, dated 11/07/13, identified subjective complaints of pain in the low back, neck and bilateral shoulders. Oral analgesics reduce the pain from 8/10 to 5/10. Objective findings included tenderness to palpation of the neck and low back. There was pain with movement of both wrists. Motor and sensory functions are not documented. Diagnoses included right shoulder impingement; right carpal and cubital tunnel syndromes and left cubital tunnel syndrome; left wrist tendonitis; neck pain referred into the upper extremities; and chronic lumbar pain referred into the extremities. There were no documented signs or symptoms or listed diagnosis of neuropathic pain. Treatment has included application of ice, acupuncture, and oral analgesics. A Utilization Review determination was rendered on 11/20/13 recommending non-certification of "Transcutaneous Electrical Nerve Stimulation (TENS) unit; eight (8) Massage sessions; Glucosamine 500mg, #90; Lidoderm patches, #5".

### IMR ISSUES, DECISIONS AND RATIONALES

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

**TRANSCUTANEOUS ELECTRICAL NERVE STIMULATION (TENS) UNIT:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Section TENS, chronic pain Page(s): 116.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 181, Chronic Pain Treatment Guidelines Section TENS Page(s): 114-117.

**Decision rationale:** The MTUS Guidelines indicate that TENS is not recommended for the neck & upper back. For other conditions, a one month trial is considered appropriate if used as an adjunct to an evidence-based program of functional restoration. The recommended types of pain include: - Neuropathic pain - CRPS I and II - Phantom limb pain - Spasticity - Multiple sclerosis For chronic intractable pain from these conditions, the following criteria must be met: - Documentation of pain for at least three months duration. - Evidence that other appropriate pain modalities have been tried (including medication) and failed. - A one-month trial period of the TENS unit should be documented with documentation of how often it was used, as well as the outcomes in terms of pain relief and function. - Other ongoing pain treatment should also be documented during the trial period including medication usage. A treatment plan including the specific short- and long-term goals of treatment with the TENS unit should be submitted. In this case, the TENS unit is being requested for a type of pain not specified as indicated for treatment. The specific target of the TENS unit is not documented. TENS is not recommended for the neck and upper back. Also, the multiple criteria noted above (documentation of duration of pain, trial plan, and goal plan) have not been met. Last, a one-month trial should be attempted. Therefore, there is no documented medical necessity for a TENS unit.

**EIGHT (8) MASSAGE SESSIONS:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Section Massage Therapy Page(s): 60.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Section Massage Therapy Page(s): 60.

**Decision rationale:** The MTUS Guidelines recommend massage therapy if it is an adjunct to other recommended treatment (e.g. exercise). The therapy should be limited to 4-6 visits in most cases. Scientific studies have shown contradictory results of efficacy. In this case, the employee has requested 8 sessions and its use as an adjunct to other treatment such as exercise is not documented. Therefore, there is no documented medical necessity for 8 sessions of massage therapy.

**GLUCOSAMINE 500 MG, #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Section Glucosamine (and Chondroitin Sulfate) Page(s): 50.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Section Glucosamine Page(s): 50.

**Decision rationale:** Glucosamine is a compound found in cartilage. The MTUS Guidelines indicate that glucosamine is recommended as an option given its low risk, in patients with moderate arthritis pain. They note that studies have demonstrated highly significant efficacy for

the crystalline form of glucosamine sulfate (GS) on all outcomes including pain and joint space narrowing. The greatest value has been demonstrated in arthritis of the knee. However, they note that similar studies are lacking for glucosamine hydrochloride. Further, they indicate that results obtained with GS may not be extrapolated to other salts (hydrochloride) or formulations (OTC or food supplements). Last, they note that studies have indicated that the effect of the combination of GS and chondroitin sulfate may be less than the effect of each treatment singly. In this case, the dose frequency

#### **LIDODERM PATCHES, #5: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Section Lidoderm (lidocaine patch) Page(s): 56-57.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Section Lidoderm (lidocaine patch) Page(s): 56-57. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Section Chronic Pain, Lidoderm.

**Decision rationale:** Lidoderm (lidocaine patch) is a topical anesthetic. The MTUS Guidelines indicate: "Topical lidocaine may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tricyclic or SNRI antidepressants or an anti-epilepsy drug such as gabapentin or Lyrica). This is not a first-line treatment and is only FDA approved for post-herpetic neuralgia." The Official Disability Guidelines (ODG) also indicate that Lidoderm is not recommended until after a trial of first-line therapy. The following criteria are listed for use: 

- Recommended for a trial if there is evidence of localized pain that is consistent with a neuropathic etiology;
- There should be evidence of a trial of first-line neuropathic medications (tricyclic or SNRI antidepressants or an AED such as gabapentin or Lyrica);
- This medication is not generally recommended for treatment of osteoarthritis or treatment of myofascial pain/trigger joints;
- An attempt to determine a neuropathic component of pain should be made;
- The area for treatment should be designated as well as number of planned patches and duration of use (number of hours per day);
- A trial of patch treatment is recommended for a short-term period;
- Continued outcomes should be intermittently measured and if improvement does not continue, lidocaine patches should be discontinued.

In this case, there is no documentation of the neuropathic component of the pain or failure of a complete trial of conventional first-line therapy. Therefore, there is no documented medical necessity for Lidoderm patches.