

Case Number:	CM14-0136810		
Date Assigned:	09/03/2014	Date of Injury:	05/01/1997
Decision Date:	10/02/2014	UR Denial Date:	07/30/2014
Priority:	Standard	Application Received:	08/25/2014

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 Practice and is licensed to practice in Texas and Mississippi. 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 70-year-old male who reported injury on 05/01/1997 due to an unknown mechanism. Diagnoses were postoperative carpal tunnel syndrome right, chronic pain, and muscle spasm. Past treatments were not reported. Diagnostic studies were not reported. Past surgeries were carpal tunnel syndrome. Physical examination on 01/07/2014 revealed complaints of chronic pain. Straight leg raise was negative. No spinal sensory level. Medications were Triamcinolone ointment, Atorvastatin, Losartan, Cyclobenzaprine, lidocaine 5% ointment, Lorazepam, Clobetasol propionate, Donnatal, Omeprazole, Advair Diskus, Furosemide, Diclofenac, Hyoscyamine sulfate, Promethazine, and Tramadol. Treatment plan was to continue home exercise, also for cervical trigger point injections. The rationale was not submitted. The Request for Authorization was submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Trigger point injections right upper extremity.: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Trigger point injections Page(s): 122.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Trigger Point Injections, Page(s): 121, 122.

Decision rationale: The decision for trigger point injections right upper extremity is not medically necessary. The California Medical Treatment Utilization Schedule recommends trigger point injections for myofascial pain syndrome and they are not recommended for radicular pain. Criteria for the use of trigger point injections include documentation of circumscribed trigger points with evidence upon palpation of a twitch response as well as referred pain. Symptoms should have been documented as "have persisted for more than 3 months." Medical management therapy such as ongoing stretching exercises, physical therapy, non-steroidal anti-inflammatory drugs (NSAIDs) and muscle relaxants should be documented as "have failed to control pain." Radiculopathy should not be present (by exam, imaging, or neuro testing), and there are to be no repeat injections unless a greater than 50% pain relief is obtained for 6 weeks after an injection and there is documented evidence of functional improvement. Additionally, they indicate that the frequency should not be at an interval less than 2 months. Past conservative care modalities were not reported. There was no spinal examination that revealed a twitch response. Radiculopathy was not proven to be not present by exam, imaging or neuro testing. Therefore, the request is not medically necessary.

Lidocaine 5% x12: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm, Page(s): 56, 57.

Decision rationale: The decision for Lidocaine 5% x12 is not medically necessary. The California Medical Treatment Utilization Guidelines indicate that topical lidocaine (Lidoderm) may be recommended for localized peripheral pain after there has been evidence of a trial of first line therapy (tri-cyclic or SNRI, antidepressants or an AED such as gabapentin or Lyrica). This is not a first-line treatment and is only FDA approved for postherpetic neuralgia. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than postherpetic neuralgia. No other commercially approved topical formulations lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. The efficacy of this medication was not reported as well as the request does not indicate a frequency for the medication. Therefore, the request is not medically necessary.

Cyclobenzaprine 10mg #90 x 2 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 64.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine, Page(s): 41, 64.

Decision rationale: The decision for Cyclobenzaprine 10mg #90 x 2 refills is not medically necessary. The California Medical Treatment Utilization Schedule states, Cyclobenzaprine (Flexeril) is recommended for a short course of therapy. Flexeril is more effective than placebo

in the management of back pain; however, the effect is modest and comes at the price of greater adverse effects. The effect is greatest in the first 4 days of treatment suggesting that shorter courses may be better. This medication is not recommended to be used for longer than 2 to 3 weeks. The efficacy of this medication was not reported as well as the request does not indicate a frequency for the medication. Therefore, the request is not medically necessary.

Tramadol 50mg #180 x 3 refills.: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol (Ultram) Page(s): 93-94.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol, Ongoing Management, Page(s): 82,93,94,113; 78.

Decision rationale: The decision for Tramadol 50mg #180 x 3 refills is not medically necessary. The California Medical Treatment Utilization Schedule states central analgesics drugs such as tramadol (Ultram) are reported to effective in managing neuropathic pain and it is not recommended as a first line oral analgesic. The medical guidelines recommend that there should be documentation of the 4 A's for ongoing monitoring including Analgesia, Activities of daily living, Adverse side effects, and Aberrant drug taking behavior. The efficacy of this medication was not reported, also, the request does not indicate a frequency for the medication. Therefore, the request is not medically necessary.