

Case Number:	CM15-0106074		
Date Assigned:	07/17/2015	Date of Injury:	04/01/2014
Decision Date:	08/19/2015	UR Denial Date:	05/22/2015
Priority:	Standard	Application Received:	06/02/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 58 year old female, who sustained an industrial injury on 4/01/2014. Diagnoses include lumbar sprain/strain with left lower extremity radiculitis and multilevel disc protrusions, stenosis and facet arthropathy, and right index trigger finger. Treatment to date has included conservative care. Documentation states 24 sessions of conservative treatment with no improvement and symptoms are worse than before. The type of treatment is not specified. Per the handwritten Primary Treating Physician's Progress Report dated 4/23/2015, the injured worker reported lower back pain with bilateral lower extremity numbness and tingling. He also reported right index finger tenderness and swelling. Physical examination of the lumbar spine revealed tenderness to palpation with guarding and spasm. Examination of the right index finger revealed tenderness to palpation A1 pulley with mild swelling. The plan of care included, and authorization was requested, for diclofenac sodium 100mg #30, omeprazole 20mg #30, gabapentin 300mg #90, cyclobenzaprine 7.5mg #60, one back brace, one pain management consultation, EMG (electromyography)/NCS (nerve conduction studies), Tylenol #3 #60, Voltaren XR 100mg #30, Fexmid 7.5mg #60, and Neurontin 300mg #90.

IMR ISSUES, DECISIONS AND RATIONALES

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

Omeprazole 20 mg Qty 30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI symptoms and cardiovascular risk.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68-69 of 127.

Decision rationale: Regarding the request for omeprazole (Prilosec), California MTUS states that proton pump inhibitors are appropriate for the treatment of dyspepsia secondary to NSAID therapy or for patients at risk for gastrointestinal events with NSAID use. Within the documentation available for review, there is no indication that the patient has complaints of dyspepsia secondary to NSAID use, a risk for gastrointestinal events with NSAID use, or another indication for this medication. In light of the above issues, the currently requested omeprazole (Prilosec) is not medically necessary.

Cyclobenzaprine HCL(hydrochloride) 7.5 mg Qty 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63-66 of 127.

Decision rationale: Regarding the request for cyclobenzaprine (Flexeril), Chronic Pain Medical Treatment Guidelines support the use of non-sedating muscle relaxants to be used with caution as a 2nd line option for the short-term treatment of acute exacerbations of pain. Guidelines go on to state that cyclobenzaprine specifically is recommended for a short course of therapy. Within the documentation available for review, there is no identification of a specific analgesic benefit or objective functional improvement as a result of the cyclobenzaprine. Additionally, it does not appear that this medication is being prescribed for the short-term treatment of an acute exacerbation, as recommended by guidelines. Finally, there is no documentation of failure of first-line treatment options, as recommended by guidelines. In the absence of such documentation, the currently requested cyclobenzaprine (Flexeril) is not medically necessary.

Right Index, Trigger Finger Injection under ultrasound guidance: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 271. Decision based on Non-MTUS Citation Official Disability Guidelines: Forearm, Wrist, and Hand (Acute & Chronic) - Injections.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 265. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, Wrist, and Hand Chapter, Ultrasound (diagnostic).

Decision rationale: Regarding the request for trigger finger injection, CA MTUS and ACOEM state that 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 two injections by the primary care or occupational medicine provider. ODG cites that ultrasound guidance for injections is not generally recommended. Within the documentation available for review, while there is tenderness and swelling noted, there is no indication of symptoms/findings consistent with significantly symptomatic trigger finger. Furthermore, there is no clear indication of ultrasound guidance and, unfortunately, there is no provision for modification of the current request. In light of the above issues, the currently requested trigger finger injection is not medically necessary.

EMG (electromyography)/ NCV (nerve conduction velocity) of Right Lower Extremity & Left Lower Extremity: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines: Low Back - Lumbar & Thoracic (Acute & Chronic) - EMGs.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Electrodiagnostic Studies.

Decision rationale: Regarding the request for EMG/NCV of the lower extremities, Occupational Medicine Practice Guidelines state that electromyography may be useful to identify subtle focal neurologic dysfunction in patients with low back symptoms lasting more than 3 to 4 weeks. ODG states that nerve conduction studies are not recommended for back conditions. They go on to state that there is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. Within the documentation available for review, while there are various symptoms/findings attributed to multiple nerve root distributions, none are suggestive of peripheral neuropathy for which the NCV component would be indicated and, unfortunately, there is no provision for modification of the current request. In light of the above issues, the currently requested EMG/NCV of the lower extremities is not medically necessary.