

Case Number:	CM15-0042883		
Date Assigned:	04/10/2015	Date of Injury:	03/14/2010
Decision Date:	05/15/2015	UR Denial Date:	02/13/2015
Priority:	Standard	Application Received:	03/06/2015

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: Orthopedic Surgery, Sports Medicine

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 48-year-old female who reported an injury on 03/14/2010 as a result of a trip and fall. The injured worker was noted to undergo urine drug screens. The documentation of 10/24/2014 indicated that the injured worker had an MRI of the neck. The injured worker was noted to be status post 2 MRIs of the lumbar spine and 2 epidural steroid injections. The physician documented the injured worker was to see a physiatrist to see if she qualified for further interventional treatment. Nerve studies of the lower extremities have not been done. In regard to the neck, the physician indicated that they did not see any results for the MRI. The injured worker had radicular component with EMGs in the past showing a C6-7 radiculopathy. New EMGs were noted to show carpal tunnel syndrome with numbness and tingling progressing over time. Related to the knee on the left, the injured worker had no recent MRI. Standing x-rays revealed 1 mm of articular surface. The request was made for repeat standing x-rays. The injured worker was noted to be status post 2 series of Hyalgan injections with relief. The injured worker had access to a DonJoy brace. The injured worker had access to a back brace, hot and cold wrap, large and small, neck collar with gel, and neck pillow. The injured worker had a hot and cold wrap for the wrist and access to a TENS unit. The objective findings revealed a positive Tinel's at the wrist, tenderness along the carpal tunnel, and aberrant 2-point discrimination with a positive Phalen's and reverse Phalen's. Abduction was no more than 90 degrees. The diagnoses included discogenic cervical condition with no MRI, although C6-7 radiculopathy was documented. Nerve studies revealed no radiculopathy in 2013, but showed entrapment at the wrist. Additional diagnoses included internal derangement of the left knee with a recent MRI and

post 2 series of Hyalgan injections with relief, and carpal tunnel syndrome bilaterally with numbness and tingling, and positive EMGs. The treatment plan included an MRI of the neck, MRI of the left knee to check for progression of disease, standing x-ray of the left knee, nerve conduction studies of the bilateral lower extremities and upper extremities, a back brace, neck traction for neck radicular component, carpal tunnel braces, injections of Hyalgan on the left knee, a psychiatry consultation, and carpal tunnel surgery on the left. Additional treatment included trazodone 50mg #60, Effexor slow release 75mg #60, Terocin patches #30, LidoPro cream 1 bottle, Flexeril 7.5mg, Nalfon 400mg, Lunesta 2mg, and the injured worker was to start Neurontin 600mg #90.

IMR ISSUES, DECISIONS AND RATIONALES

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

Carpal Tunnel Release Surgery: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Carpal Tunnel Syndrome (Acute & Chronic).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 270-271.

Decision rationale: The American College of Occupational and Environmental Medicine guidelines indicate that a referral for hand surgery consultation may be indicated for injured workers who have red flags of a serious nature; fail to respond to conservative management, including worksite modifications and who have clear clinical and special study evidence of a lesion that has been shown to benefit, in both the short and long term, from surgical intervention. Carpal Tunnel Syndrome must be proved by positive findings on clinical examination and the diagnosis should be supported by nerve-conduction tests before surgery is undertaken. The clinical documentation submitted for review indicated the injured worker had objective findings upon physical examination. However, there was a lack of documentation of a failure of conservative care including bracing and injections. Additionally, there was a lack of documentation of nerve conduction studies to corroborate findings. The request as submitted failed to indicate the laterality for the request. Given the above, the request is not medically necessary.

Associated Surgical Service: Carpal Tunnel Brace: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

MRI of the Neck without contrast: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back (Acute & Chronic).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck & Upper Back Chapter, Magnetic resonance imaging (MRI).

Decision rationale: The Official Disability Guidelines indicate a repeat MRI is not routinely recommended and should be reserved for a significant change in symptoms and of findings suggestive of significant pathology. The clinical documentation submitted for review indicated the injured worker had been diagnosed with radiculopathy per MRI. The physician documentation indicated that he could not find MRI results. There was a lack of clarification. There was a lack of documentation of objective findings including myotomal and dermatomal findings to support the necessity for an MRI. Given the above, the request is not medically necessary.

MRI of the Left Knee without contrast: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343 and 347. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee & Leg (Acute & Chronic).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg Chapter, MRI 1/2s (magnetic resonance imaging).

Decision rationale: The Official Disability Guidelines indicate a repeat MRI may be appropriate post-surgically if needed to assess knee cartilage repair. The clinical documentation submitted for review indicated an MRI of the left knee was needed to look for progression of the disease. There was a lack of documentation of objective findings and subjective complaints to support the necessity for a repeat MRI. Given the above, the request is not medically necessary.

Associated Surgical Service: EMG/NCV of the Bilateral Upper Extremities: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Cervical Traction Unit Air Bladder: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Neck and Upper Back (Acute & Chronic).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck & Upper Back Chapter, Traction (mechanical).

Decision rationale: The Official Disability Guidelines indicate that mechanical traction is recommended for injured workers with radicular symptoms in conjunction with a home exercise program. The clinical documentation submitted for review failed to indicate the injured worker would be utilizing the unit in conjunction with a home exercise program. The duration of use was not noted. There was a lack of documentation indicating whether the unit was for rental or purchase. Given the above, the request is not medically necessary.

Lumbar Back Support and Back Support Insert: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298 and 301.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

Decision rationale: The American College of Occupational and Environmental Medicine guidelines indicate that lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. Additionally, continued use of back braces could lead to deconditioning of the spinal muscles. The clinical documentation submitted for review indicated the injured worker had access to a lumbar spine support. There was a lack of documentation indicating the injured worker had spinal instability. There was a lack of documentation of exceptional factors to warrant nonadherence to guideline recommendations. Given the above, the request is not medically necessary.

Hyalgan Injections (#5): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee & Leg (Acute & Chronic).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg Chapter, Hyaluronic Acid Injections.

Decision rationale: The Official Disability Guidelines indicate that repeat Hyalgan injections are appropriate if there is documented significant improvement in symptoms for 6 months or more. The clinical documentation submitted for review indicated the injured worker had prior injections. However, there was a lack of documentation of significant improvement in symptoms

for 6 months or more. Additionally, the request as submitted failed to indicate the laterality for the injections and the location. Given the above, the request is not medically necessary.

Cyclobenzaprine 7.5mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63.

Decision rationale: The California MTUS guidelines recommend muscle relaxants as a second line option for the short-term treatment of acute low back pain, less than 3 weeks and there should be documentation of objective functional improvement. There was a lack of documentation of objective functional improvement and exceptional factors to support continued use of the medication. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request is not medically necessary.

Gabapentin 600mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepileptic Drugs Page(s): 16.

Decision rationale: The California MTUS guidelines recommend antiepilepsy medications as a first line medication for treatment of neuropathic pain. There should be documentation of an objective decrease in pain of at least 30 % - 50% and objective functional improvement. There was a lack of documentation of an objective decrease in pain of at least 30 % - 50% and objective functional improvement. The request as submitted failed to include the frequency for the requested medication. Given the above, the request is not medically necessary.

Lidopro Ointment 121gm: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Salicylate Topicals, Topical Analgesic, Topical Capsaicin, Lidocaine Page(s): 105, 111, 28, 112. Decision based on Non-MTUS Citation Drugs.com website (www.drugs.com).

Decision rationale: The California Medical Treatment Utilization Schedule guidelines indicate that topical analgesics are largely experimental in use with few randomized control trials to determine efficacy or safety are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least

one drug (or drug class) that is not recommended is not recommended. Capsaicin: Recommended only as an option in patients who have not responded or are intolerant to other treatments. There have been no studies of a 0.0375% formulation of capsaicin and there is no current indication that this increase over a 0.025% formulation would provide any further efficacy. The 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). No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. The guidelines recommend treatment with topical salicylates. Per drugs.com, LidoPro is a topical analgesic containing capsaicin / lidocaine / menthol / methyl salicylate. There was a lack of documentation of a trial and failure of antidepressants and anticonvulsants and that the pain had not responded or was intolerant of other treatments. The request as submitted failed to include the body part to be treated and the frequency for the requested medication. Given the above, the request is not medically necessary.

Pantoprazole 20mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Proton Pump Inhibitors (PPIs), NSAIDs, GI Symptoms & cardiovascular risk.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 69.

Decision rationale: The California MTUS guidelines recommend proton pump inhibitors for injured workers at intermediate risk or higher for gastrointestinal events and are also for the treatment of dyspepsia secondary to NSAID therapy. There was a lack of documentation indicating the injured worker was at intermediate or higher risk for gastrointestinal events or had dyspepsia. The request as submitted failed to include the frequency for the requested medication. Additionally, the NSAIDS that was concurrently being reviewed was not medically necessary. Given the above, the request is not medically necessary.

Terocin patches #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Salicylate Topicals, Topical Analgesic, Lidocaine Page(s): 105, 111, 112. Decision based on Non-MTUS Citation National Library of Medicine's Daily Med Database (<http://dailymed.nlm.nih.gov>).

Decision rationale: The California Medical Treatment Utilization Schedule guidelines indicate that topical analgesics are largely experimental in use with few randomized control trials to determine efficacy or safety are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The 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 anti-depressants or an AED such as gabapentin or Lyrica). No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. The guidelines recommend treatment with topical salicylates. Per dailymed.nlm.nih.gov, Terocin patches are topical Lidocaine and Menthol. There was a lack of documentation of a trial and failure of antidepressants and anticonvulsants. The request as submitted failed to include the body part to be treated and the frequency for the requested medication. Given the above, the request is not medically necessary.

Nalfon 400mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 67.

Decision rationale: The California MTUS guidelines indicate that NSAIDS are recommended for short-term symptomatic relief of mild to moderate pain. There should be documentation of objective functional improvement and an objective decrease in pain. There was a lack of documentation of objective functional improvement and an objective decrease in pain. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request is not medically necessary.