MAXIMUS Federal Services

Case Number:	CM15-0074351		
Date Assigned:	04/24/2015	Date of Injury:	03/01/2010
Decision Date:	05/21/2015	UR Denial Date:	04/10/2015
Priority:	Standard	Application Received:	04/20/2015

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 56-year-old female patient who sustained an industrial injury on 03/01/2010. A primary treating office visit dated 10/01/2014 reported subjective complaints of left wrist pain. She does report benefitting from the use of LidoPro lotion and Terocin patches for pain reduction. In addition, she gets some relief with the use of ice/heat as needed. The pain at times prevents her from going to sleep and or awakens her from sleep. She is diagnosed with CMC joint inflammation and arthritis bilaterally, status post intervention on the right in 2011. The plan of care involved: pending left excision of the left trapezium and stabilization with tendon transfer, after kidney transplant occurs. Recommending she continue using both LidoPro and Terocin as the patient doesn't take oral analgesia due to pending renal transplant. A therapy note dated 04/06/2015 described the patient progressing towards goals with improving range of motion and strength, but residual stiffness remains. She will continue with therapy. A progress report dated April 1, 2015 indicates that the patient complains of thumb and left wrist pain. The patient has undergone 15 therapy sessions and has 9 to go. She does not have a tens unit. Diagnoses include CMC joint inflammation and chronic regional pain syndrome affecting the left hand. The treatment plan recommends a silly block, bone scan, Neurontin, Norco, mobilization, Flexeril, Norco, and a tens unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

Flexeril 7.5mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 64-66.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) 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 because 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.

TENS/IF Unit with conductive garment (indefinite use): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 118-120 of 127.

Decision rationale: Regarding the request for TENS/IF Unit, in order for a combination device to be supported, there needs to be guideline support for all incorporated modalities. Chronic Pain Medical Treatment Guidelines state that TENS is not recommended as a primary treatment modality, but a one month home-based TENS trial may be considered as a noninvasive conservative option if used as an adjunct to a program of evidence-based functional restoration. Guidelines go on to state the galvanic stimulation is not recommended. Additionally, guidelines state that interferential current stimulation is not recommended as an isolated invention except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. Within the documentation available for review, there is no indication that the patient is failed a TENS unit trial, as recommended by guidelines prior to an interferential unit trial. Furthermore, there is no indication that the patient has undergone a TENS unit trial with documentation of objective improvement and reduction in medication use, to support the TENS unit request. As such, the currently requested TENS/IF Unit is not medically necessary.

Consultation for stellate block: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Chapter 6, page 112, Pain Suffering and the Restoration of Function.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MTUS (Effective July 18, 2009), 8 C.C.R.9792.20 - 9792.26 Page(s): 103-104 of 127. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Chronic Pain Chapter, CRPS, sympathetic blocks (therapeutic).

Decision rationale: Regarding the request for Consultation for stellate block, Chronic Pain Medical Treatment Guidelines state that stellate ganglion blocks are generally limited to diagnosis and therapy for CRPS. ODG state that there should be evidence that all other diagnoses have been ruled out before consideration of use, as well as evidence that the Budapest criteria have been evaluated for and fulfilled. The guidelines go on to state that if a sympathetic block is utilized for diagnosis, there should be evidence that the block fulfills criteria for success including increased skin temperature after injection without evidence of thermal or tactile sensory block. Documentation of motor and/or sensory block should also occur. For therapeutic injections, guidelines state that they are only recommended in cases that have positive response to diagnostic blocks and diagnostic criteria are fulfilled. Within the documentation available for review, there is no indication that the Budapest criteria have been evaluated for and fulfilled, and there is no documentation of failed conservative treatment directed toward this issue. In the absence of such documentation, the currently requested Consultation for stellate block is not medically necessary.