

Case Number:	CM13-0034977		
Date Assigned:	04/25/2014	Date of Injury:	07/15/2005
Decision Date:	06/11/2014	UR Denial Date:	01/17/2013
Priority:	Standard	Application Received:	10/24/2013

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 Orthopedic Surgery, and is licensed to practice in California. 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:

This 56-year-old female cook reported onset of neck, back and right upper extremity pain relative to performing her usual and customary job duties, date of injury 7/15/05. The 10/3/13 treating physician report cited an increase in neck and bilateral shoulder pain. Pain radiated down the arms, right more than left, with numbness and tingling into her hands with weakness. She had difficulty holding objects and with fine motor skills. Low back pain was reported radiating down the leg with numbness and tingling to the bottom of her feet, right greater than left. Functional difficulty was reported with prolonging standing, walking and sitting. She was able to perform basic household chores. Medication refill was requested as they helped her to be functional. Comorbidities included hypertension, gastroesophageal reflux disease, and diabetes mellitus. Physical exam finding documented bilateral cervical and lumbar paraspinal tenderness, limited cervical range of motion, positive cervical and lumbar facet loading, slightly decreased sensation globally on the right side, 5-/5 right shoulder abduction strength, decreased bilateral intrinsic and grip strength, mild sacroiliac joint discomfort., and spasms bilateral legs. The diagnosis was neck pain with referred pain into the upper extremities, right shoulder impingement syndrome, and low back pain. The treatment plan indicated that a cervical pillow, cervical collar, hot/cold wrap, and replacement TENS unit pads were dispensed. Medications were dispensed including Flexeril 7.5 mg #60, Topamax 50 mg #60, Ultracet 37.4/325 mg #60, Naproxen 550 mg #60, and Protonix 20 mg #60. Authorization of repeat cervical and lumbar MRIs and upper/lower extremity EMG was requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

RETROSPECTIVE REQUEST FOR FLEXERFIL 7.5MG X 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63. Decision based on Non-MTUS Citation ODG, Pain Chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MUSCLE RELAXANTS (FOR PAIN) Page(s): 63-66. Decision based on Non-MTUS Citation ODG, Pain Chapter.

Decision rationale: Under consideration is a request for Flexeril 7.5 mg #60. The California MTUS guidelines recommend the use of non-sedating muscle relaxants with caution as a second-line option for short term treatment of acute exacerbations of chronic lower back pain. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. Flexeril is recommended as an option in the management of back pain, but is not recommended for longer than 2 to 3 weeks. Guideline criteria have not been met. Records indicate that Flexeril has been used since 7/18/05, with monthly dispensing of this medication documented since 4/26/13. There is no compelling reason to support the continued medical necessity of Flexeril in the absence of guideline recommendations for use beyond several weeks. There is no specific documentation of a functional benefit associated with use. Therefore, this retrospective request for Flexeril 7.5 mg #60 is not medically necessary.

RETROSPECTIVE REQUEST FOR TOPAMAX 50MG X 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ANTIPILEPSY DRUGS (AEDS), Page(s): 16-22.

Decision rationale: Under consideration is a request for Topamax 50 mg #60. The California MTUS recommends the use of anti-epilepsy drugs (AEDs) for neuropathic pain. Topamax (Topiramate) is an AED and may be considered for use when other anticonvulsants fail. Guidelines indicate a "good response" is a 50% reduction in pain and a "moderate" response to the use of anti-epilepsy drugs is a 30% reduction in pain. Guideline criteria have not been met. Records suggest that Neurontin was previously used. Topamax has been prescribed for neuropathic pain. There is no indication how long this medication has been used or what specific pain reduction or functional benefit has been achieved. Therefore, this retrospective request for Topamax 50 mg #60 is not medically necessary.

RETROSPECTIVE REQUEST FOR CERVICAL COLLAR: 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 Chapter.

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

Decision rationale: Under consideration is a retrospective request for a cervical collar. The California MTUS guidelines are silent regarding cervical collars in chronic injuries. The Official Disability Guidelines state that cervical collars are not recommended for neck sprains. Collars may be appropriate where post-operative and fracture indications exist, or in the emergent setting. Guideline criteria have not been met. The patient has chronic neck pain, has not undergone surgery, and has no fracture indications. There is no compelling reason to support the medical necessity of a cervical collar for this patient. Therefore, this retrospective request for a cervical collar is not medically necessary.

RETROSPECTIVE REQUEST FOR FOR CERVICAL PILLOW: Overturned

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 Chapter.

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

Decision rationale: Under consideration is a retrospective request for cervical pillow. The California Medical Treatment Utilization Schedule is silent regarding cervical pillows in chronic injuries. The Official Disability Guidelines recommend the use of a support pillow while sleeping, in conjunction with daily exercise. Guideline criteria have been met. The patient presented with increased neck pain and difficulty sleeping. Prior instruction in an independent home exercise program is noted in the records. The use of a cervical pillow in conjunction with her home therapy program is consistent with guidelines. Therefore, this retrospective request for a cervical pillow is medically necessary.

RETROSPECTIVE REQUEST FOR ULTRACET 37.5/325MG TIMES 60: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 79-80,81.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 76-80.

Decision rationale: Under consideration is a retrospective request for Ultracet 37.5/325 mg #60. The California MTUS indicates that Ultracet (Tramadol and Acetaminophen) is recommended for moderate to severe pain. If used on a long-term basis, the criteria for use of opioids should be followed. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. The Tramadol dose is

recommended not to exceed 400 mg per day. Guideline criteria have been met. The patient had been using Ultracet for pain management since 9/6/05. Records indicate that the pain is generally reduced by VAS 3/10 with medication use and allows her to maintain her current level of function. This is the only analgesic medication being prescribed and is relatively low-dose. Therefore, this retrospective request for Ultracet 37.5/325 mg #60 is medically necessary.

RETROSPECTIVE REQUEST FOR PROTONIX 20MG TIMES 60: 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), Pain Chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms and Cardiovascular Risk Page(s): 68-69.

Decision rationale: Under consideration is a retrospective request for Protonix 20 mg #60. The California MTUS guidelines recommend the use of proton pump inhibitors (PPIs), for patients using non-steroidal anti-inflammatory drugs (NSAIDs) at risk for gastrointestinal events, but do not address the use of Protonix. The Official Disability Guidelines state that Protonix is recommended as a second-line medication if a trial of Omeprazole (Prilosec) is not effective. Guideline criteria have not been met. The long-term use of Prilosec was noted in the records. Prilosec was dispensed on 8/1/13 for stomach upset associated with taking medications. On 10/3/13, the patient was prescribed Protonix with no documentation of any increase in gastrointestinal complaints or indication that Prilosec was no longer effective. Therefore, this retrospective request for Protonix 20 mg #60 is not medically necessary.

RETROSPECTIVE REQUEST FOR COMPRESSION THERAPY GARMENT: 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 Chapter).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic, Cold/Heat Packs.

Decision rationale: Under consideration is a request for a compression therapy garment. Records state that compression wraps were dispensed for hot and cold therapy to the back. The California MTUS are silent regarding compression therapy garments. The Official Disability Guidelines recommend the use of cold/heat packs as an option for acute pain, but indicate there is minimal evidence for the long term use of cold therapy in low back complaints. Heat therapy has been found to be helpful for pain reduction and return to normal function. Guideline criteria have not been met. There is no compelling reason to support the medical necessity of a compression wrap to supply hot or cold therapy to the back. Simple heat/cold packs are supported by guidelines for acute use, and continuous low level heat wrap therapy is supported

for use in chronic low back pain. The addition of compression is not supported by guidelines. Therefore, this retrospective for a compression therapy garment is not medically necessary.