

Case Number:	CM13-0042240		
Date Assigned:	12/27/2013	Date of Injury:	10/16/2012
Decision Date:	06/02/2014	UR Denial Date:	10/11/2013
Priority:	Standard	Application Received:	10/28/2013

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 Physical Medicine & Rehabilitation 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:

The injured worker is a 58-year-old female who reported an injury on 10/16/2012, secondary to a fall. Current diagnoses include cervical degenerative disc disorder, cervical facet syndrome, lumbar disc degeneration, and lumbar facet syndrome. The latest Physician Progress Report submitted for this review is documented on 04/27/2013. The injured worker has been previously treated with muscle relaxants, aquatic therapy and a cervical spine nerve block. The injured worker reported 6/10 neck and back pain. Current medications include Norco 5/500 mg, orphenadrine, and Soma. Physical examination revealed a moderately antalgic gait, paraspinal tenderness in the cervical spine, restricted cervical range of motion, intact sensation in the bilateral upper extremities, moderate tenderness and spasm of the bilateral paraspinal muscles, positive facet loading maneuver, and diminished lumbar range of motion. Treatment recommendations at that time included continuation of a home exercise program, lumbar medial branch nerve blocks, cervical facet injections, and continuation of current medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

PRESCRIPTION OF HYDROCODEINE 10MG: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

Decision rationale: The MTUS Chronic Pain Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of nonopioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects should occur. This is a nonspecific request that does not include the frequency or quantity. Therefore, the request cannot be determined as medically appropriate. As such, the request is is not medically necessary and appropriate.

PRESCRIPTION OF ORPHENADRINE 100MG: Upheld

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

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

Decision rationale: The MTUS Chronic Pain Guidelines state muscle relaxants are recommended as nonsedating second line options for short term treatment of acute exacerbations. This is a nonspecific request that does not include the frequency or quantity of use for this muscle relaxant. As such, the request is is not medically necessary and appropriate.

CONTINUATION OF PSYCH GROUP THERAPY (X6): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 301. Decision based on Non-MTUS Citation ODG Treatment in Workers Compensation, 7th edition, Cognitive behavioral therapy (CBT).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Behavioral interventions Page(s): 23.

Decision rationale: The MTUS Chronic Pain Guidelines utilize the Official Disability Guidelines cognitive behavioral therapy guidelines for chronic pain, which allow for an initial trial of 3 to 4 psychotherapy visits over 2 weeks. With evidence of objective functional improvement, a total of up to 6 to 10 visits over 5 to 6 weeks may be appropriate. The injured worker has completed an unknown amount of psychotherapy sessions to date. There is no evidence of objective functional improvement. Therefore, ongoing treatment cannot be determined as medically appropriate. As such, the request is not medically necessary and appropriate.

URINE ANALYSIS (10/17/13 AND 8/26/13): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 43,77, 89. Decision based on Non-MTUS Citation Official Disability Guidelines.

Decision rationale: MTUS Chronic Pain Guidelines state drug testing is recommended as an option, using a urine drug screen to assess for the use or presence of illegal drugs. Official Disability Guidelines state the frequency of urine drug testing should be based on documented evidence of risk stratification. There is no documentation of noncompliance or misuse of medication. There is also no indication that this injured worker falls under a high risk category that would require frequent monitoring. Therefore, the medical necessity for repeat testing has not been established. As such, the request is not medically necessary and appropriate.

L/S REHAB KIT: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

Decision rationale: Official Disability Guidelines state home exercise kits are recommended as an option where home exercise programs are also recommended. As per the documentation submitted, the injured worker's physical examination only revealed limited lumbar range of motion with tenderness to palpation. The injured worker demonstrated 5/5 motor strength in the bilateral lower extremities with intact sensation. There is no documentation of a significant musculoskeletal or neurological deficit that would warrant the need for a rehab kit as opposed to a traditional home exercise program. The medical necessity has not been established. Therefore, the request is not medically necessary and appropriate.

PRESCRIPTION OF CAPSAICIN 60GR X2 PER MONTH APPLY BID, L/S, C/S: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: The MTUS Chronic Pain Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Capsaicin is recommended only as an option in patients who have not responded or are intolerant to other treatments. There is no mention of a contraindication or a failure to respond to first line oral medication prior to the initiation of a topical analgesic. There is also no strength listed in the current request. As such, the request is not medically necessary and appropriate.

ENOVA RX IBUPROFEN 10% 60 GRAMS CREAM: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: The MTUS Chronic Pain Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. The only FDA approved topical NSAID is Diclofenac. Therefore, the current request is not medically appropriate. There is also no frequency listed in the current request. As such, the request is not medically necessary and appropriate.

LIVER FUNCTION: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 70.

Decision rationale: The MTUS Chronic Pain Guidelines recognize the risk for liver and kidney problems due to long term and high dose use of NSAIDs and acetaminophen. There has been a recommendation to measure liver transaminases within 4 to 8 weeks after starting therapy. Repeat testing should be based on patient risk factors and related symptoms. As per the documentation submitted, the injured worker does not exhibit any signs or symptoms suggestive of an abnormality due to medication use. Therefore, the medical necessity has not been established. As such, the request is not medically necessary and appropriate.