

Case Number:	CM13-0046096		
Date Assigned:	12/27/2013	Date of Injury:	05/06/2008
Decision Date:	05/27/2014	UR Denial Date:	10/24/2013
Priority:	Standard	Application Received:	11/12/2013

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 Anesthesiology, has a subspecialty in Pain Management 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 patient is an [REDACTED] employee who has filed a claim for low back pain radiating to both lower extremities and left shoulder pain associated with an industry injury of May 06, 2008. Thus far, the patient has been treated with surgery to the left shoulder on August 2009, March 2011, and May 10, 2013; physical therapy and acupuncture to the left shoulder; and two knee surgeries, opioids, acupuncture and physical therapy to the knee and use of knee brace. MRI of the left shoulder performed September 18, 2012 showed post-surgical changes, old Hill-Sachs deformity of the humeral head, and tear of the superior labrum and attachment of the biceps tendon. X-ray of the left shoulder performed in January 26, 2013 showed no evidence of dislocation. Lumbar MRI performed February 2011 showed a 45-mm left sided disc with moderate central and lateral recess narrowing at L4-L5. Neurodiagnostic report of February 2011 showed possible left chronic lumbar radiculopathy. In a utilization review report of October 24, 2013, the claims administrator denied a request for Norco; cyclo-keto-lido cream as there are no guidelines to support the use of it; flexeril as guidelines state it is not recommended to be used for longer than 2-3 weeks; and physical therapy as there has already been 12 authorized sessions. Review of progress notes shows that patient also experiences psychiatric symptoms of anxiety, depression, and sleep problems for which he has psychiatric care and medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

ONE PRESCRIPTION OF NORCO 5/325MG, 60 COUNT WITH ONE REFILL: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Norco (Hydrocodone/Acetaminophen).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 79-81.

Decision rationale: As noted on page 79-81 of the Chronic Pain Medical Treatment Guidelines, there is no support for ongoing opioid treatment unless there is ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. There has been note of use of Norco since March 2013; however there is no clear documentation regarding symptomatic and functional benefits derived from this medication, as well as monitoring of proper use. Therefore, based on guidelines and a review of the evidence, the request for Norco 5/325mg is not medically necessary.

CYCLO-KETO-LIDO CREAM, 240G WITH ONE REFILL: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 112-113.

Decision rationale: As noted on page 112-113 of the Chronic Pain Medical Treatment Guidelines, ketoprofen, lidocaine (in creams, lotion or gels), capsaicin in a 0.0375% formulation, baclofen and other muscle relaxants, and gabapentin and other antiepilepsy drugs are not recommended for topical applications. Therefore, based on guidelines and a review of the evidence, the request for Cyclo-Keto-Lido Cream, 240g is not medically necessary.

FLEXERIL 7.5MG, 60 COUNT WITH ONE REFILL: Upheld

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

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

Decision rationale: As stated in CA MTUS Chronic Pain Medical Treatment Guidelines page 63, non-sedating muscle relaxants are recommended with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP. They also show no benefit beyond NSAIDs in pain and overall improvement. There is already note of use of NSAIDs in this patient (Naproxen), and patient does not present with acute type of pain. Therefore, based on guidelines and a review of the evidence, the request for Flexiril 7.5mg is not medically necessary.

SIX PHYSICAL THERAPY SESSIONS: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: AMERICAN COLLEGE OF OCCUPATIONAL AND ENVIRONMENTAL MEDICINE (ACOEM), 2ND EDITION, (2004) CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, PAIN, SUFFERING, AND RESTORATION OF FUNCTION CHAPTER, PAGE 114; PAGES 98-99 and Official Disability Guidelines (ODG) Shoulder chapter, Physical therapy.

Decision rationale: Page 98-99 of the Chronic Pain Medical Treatment Guidelines and page 114 of the MTUS ACOEM Guidelines stress the importance of a time-limited treatment plan with clearly defined functional goals, frequent assessment and modification of the treatment plan based upon the patient's progress in meeting those goals, and monitoring from the treating physician regarding progress and continued benefit of treatment is paramount. In this case, there is note of improvement of the shoulder with post-operative PT scheduled as twice a week for 6 weeks. ODG recommends 24 visits over 14 weeks for post-arthroscopic shoulder procedures. However, this request does not specify which body part the physical therapy sessions are for, and there is no documentation regarding any functional or objective benefits provided by the first set of 12 PT sessions that would warrant continuation of PT sessions. Therefore, based on guidelines and a review of the evidence, the request for 6 Physical Therapy Sessions is not medically necessary.