

Case Number:	CM13-0053810		
Date Assigned:	12/30/2013	Date of Injury:	03/09/2012
Decision Date:	04/30/2014	UR Denial Date:	10/31/2013
Priority:	Standard	Application Received:	11/18/2013

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 and Rehabilitation and Pain Management, and is licensed to practice in Texas. 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 a 66-year-old male who reported an injury on 03/09/2012. The mechanism of injury was not stated. The patient is diagnosed with lumbar radiculopathy and left shoulder impingement syndrome. The patient was seen by [REDACTED] on 10/21/2013. Physical examination revealed tenderness to palpation of the left shoulder with mildly decreased range of motion and positive impingement sign. The patient also demonstrated paravertebral muscle tenderness with spasm and restricted range of motion of the lumbar spine, positive straight leg raising on the left, and reduced sensation in the left foot. Treatment recommendations included a course of chiropractic treatment and prescriptions for Hydrocodone 10/325 mg, Ketoprofen 75 mg, Omeprazole DR 20 mg, Orphenadrine ER 100 mg, and Medrox pain relief ointment.

IMR ISSUES, DECISIONS AND RATIONALES

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

HYDROCODONE (NORCO) APAP 10/325MG #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 91.

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

Decision rationale: California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. As per the documentation submitted, the patient has utilized Hydrocodone 10/325 mg since 10/2012. Despite ongoing use of this medication, the patient continues to report persistent symptoms. Satisfactory response to treatment has not been indicated by a decrease in pain level, increase in function, or improved quality of life. Therefore, the request is non-certified.

KETOPROFEN 75MG #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67-72.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67-72.

Decision rationale: California MTUS Guidelines state NSAIDs are recommended for osteoarthritis at the lowest dose for the shortest period in patients with moderate to severe pain. For acute exacerbations of chronic pain, NSAIDs are recommended as a second line option after acetaminophen. There is no evidence of long term effectiveness for pain or function. As per the documentation submitted, there is no evidence of a failure to respond to first line treatment with acetaminophen as recommended by California MTUS Guidelines. As guidelines do not recommend long term use of this medication, the current request cannot be determined as medically appropriate. Therefore, the request is non-certified.

OMEPRAZOLE DR 20MG #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68-69.

Decision rationale: California MTUS Guidelines state proton pump inhibitors are recommended for patients at intermediate or high risk for gastrointestinal events. Patients with no risk factor and no cardiovascular disease do not require the use of a proton pump inhibitor, even in addition to a non-selective NSAID. There is no evidence of cardiovascular disease or increased risk factors for gastrointestinal events. Therefore, the patient does not meet criteria for the requested medication. As such, the request is non-certified.

ORPHENADRINE ER 100MG #60: Upheld

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

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

Decision rationale: California MTUS Guidelines state muscle relaxants are recommended as non-sedating second line options for short term treatment of acute exacerbations. Efficacy appears to diminish over time and prolonged use may lead to dependence. As per the documentation submitted, the patient does demonstrate palpable muscle spasm in the lumbar spine. However, guidelines do not recommend long term use of this medication. Therefore, the request is not medically appropriate. As such, the request is non-certified.

MEDROX PAIN RELIEF OINTMENT: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 11-113.

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

Decision rationale: California MTUS Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Any compounded product that contains at least 1 drug that is not recommended is not recommended as a whole. Capsaicin is recommended only as an option in patients who have not responded or are intolerant to other treatments. There is no evidence of a failure to respond to first line oral medication. There was also no strength or quantity listed in the current request. Therefore, the request is not medically appropriate. As such, the request is non-certified.

CHIROPRACTIC TREATMENT FOR THE LEFT SHOULDER AND LOWER BACK (3 TIMES PER WEEK FOR 4 WEEKS): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines manual therapy and manipulation Page(s): 58.

Decision rationale: California MTUS Guidelines state manual therapy and manipulation is recommended for chronic pain if caused by musculoskeletal conditions. Treatment for the low back is recommended as an option with a therapeutic trial of 6 visits over 2 weeks. The current request for 12 sessions of chiropractic therapy exceeds guideline recommendations. Based on the clinical information received and the California MTUS Guidelines, the request is non-certified.

PAIN MANAGEMENT EVALUATION: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 89-92.

Decision rationale: California MTUS/ACOEM Practice Guidelines state referral may be appropriate if the practitioner is uncomfortable with the line of inquiry, with treating a particular cause of delayed recovery, or has difficulty obtaining information or an agreement to a treatment plan. As per the documentation submitted, a pain management consultation was requested for a possible epidural steroid injection. However, there is no evidence of an exhaustion of conservative treatment prior to the request for a specialty referral. There was no imaging studies provided for review. Based on the clinical information received, the request is non-certified.