

Case Number:	CM13-0066999		
Date Assigned:	01/03/2014	Date of Injury:	05/09/2001
Decision Date:	04/21/2014	UR Denial Date:	12/05/2013
Priority:	Standard	Application Received:	12/17/2013

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 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 a 64 year old female who was injured on 05/09/2011. The patient has been diagnosed with right shoulder impingement syndrome and cervical radiculopathy. 08/27/2013, 11/22/2013, and 12/30/2013 medications list include: Aciphex 20 mg, Amitriptyline 50 mg, Aspirin 325 mg, Butrans 20 mcg, Celebrex 200 mg, Cymbalta 60 mg, Flector Patch 1.3% Patch, Glucophage 500 mg, Hydroxychloroquine 200 mg, Lidoderm 5% Patch, extended release (2 patches 12 hours on and 12 hours off), Lisinopril 20 mg, Lunesta 3 mg, Lyrica 50 mg, Norco 10-325 mg, Pancrease capsules, Tenormin 50 mg, Tolzamide 500 mg, Zanaflex 4 mg. PR2 dated 12/30/2013 indicated the patient was in for a follow up evaluation of her shoulder pain, with a severity of a 7/10. She noted her pain as a 6/10 on 11/22/2013 visit and a 7/10 on the 08/27/2013 visit. The condition is located in the right shoulder. She has had worsening symptoms and requires an updated evaluation. Objective findings on exam revealed difficulty walking, headaches, numbness, neurological symptoms or problems; and difficulty sleeping. Her muscle strength for all groups is 5/5; muscle tone is normal; positive impingement test is moderate on the right. There is tenderness at the AC joint, severe right, anterior capsule. There is moderate tenderness on the right and posterior capsule; deep tendon reflexes are normal. Neurological examination revealed abduction of approximately 40 degrees, flexion of 125 to 130 degrees, and extension of 20 degrees. There is marked reduction and internal and external rotation as well and this has worsened with a greater pain response and less (ROM) range of motion (Physical exam is unchanged since 11/22/2013 and 08/27/2013 visits). There is no urine drug screen provided or documented.

IMR ISSUES, DECISIONS AND RATIONALES

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

ACIPHEX 20MG #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68-69.

Decision rationale: Aciphex is a proton pump inhibitor and as per CA MTUS guidelines, PPI is recommended for patients at intermediate risk for gastrointestinal events. In this case, this patient has reported no subjective complaints of abdominal pain or discomfort and there is no documentation of GI events or ulcers. Thus, the medical necessity has not been established and the request is non-certified.

AMITRIPTYLINE 50MG #240: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Amitriptyline Page(s): 13.

Decision rationale: As per CA MTUS, Amitriptyline is a tricyclic antidepressant recommended as a first line option for neuropathic pain, and as a possibility for non-neuropathic pain. Tricyclics are generally considered a first-line agent unless they are ineffective, poorly tolerated or contraindicated. Guidelines also indicate that assessment of treatment efficacy should include not only pain outcomes, but also an evaluation of function, changes in use of other analgesic medication, sleep quality and duration, and psychological assessment. Further guidelines indicate that long-term effectiveness of anti-depressants has not been established. In this case, this patient has chronic neuropathic pain and is taking this medication chronically. This patient is also taking another anti-depressant, Cymbalta, for neuropathic pain. There is no clinical rationale submitted why there is a need of 2 antidepressants. Thus, the request is non-certified.

BUTRANS 20MCG #7: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Buprenorphine Page(s): 26-27.

Decision rationale: As per CA MTUS guidelines, Butrans contains Buprenorphine which is recommended for opioid addiction and as an option for chronic pain, especially after detoxification in patients who have a history of opiate addiction. The records submitted revealed

no mention of opiate addiction or previous detoxification. Thus, the medical necessity has not been established and the request is non-certified.

CELEBREX 200MG #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, hypertension and renal function Page(s): 69-70.

Decision rationale: As per CA MTUS guidelines, all NSAIDs have the potential to raise blood pressure in susceptible patients. In this case, this patient has a history of hypertension and a most recent note dated 01/29/2014 indicates his blood pressure reading was 142/94. Thus, the medical necessity has not been established and the request is non-certified.

CYMBALTA 60MG #30: 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 Duloxetine (Cymbalta) Page(s): 15-16.

Decision rationale: As per CA MTUS guidelines, Cymbalta is "FDA-approved for anxiety, depression, diabetic neuropathy, and fibromyalgia. Used off-label for neuropathic pain and radiculopathy. Duloxetine is recommended as a first-line option for diabetic neuropathy. No high quality evidence is reported to support the use of duloxetine for lumbar radiculopathy. More studies are needed to determine the efficacy of duloxetine for other types of neuropathic pain." In this case, this patient has been diagnosed with lumbar disc herniation with DDD, facet syndrome, bilateral hip osteoarthritis, and rotator cuff syndrome. There is no documented evidence to support the diagnoses of fibromyalgia, diabetic neuropathy, anxiety or depression. Thus, the medical necessity has not been established and the use of Cymbalta is not medically necessary and appropriate. The request is non-certified.

NORCO 10/325MG #150: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use Page(s): 76-82.

Decision rationale: As per CA MTUS guidelines, "four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids; pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or

nonadherent) drug-related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors)." In this case, records review indicates that this patient has chronic neuropathic pain and has been prescribed Norco for long periods of time. For the past few months, this patient has consistently reported the pain level as 7-8/10 with no reduction in pain level and no documentation of functional improvement with the use of this medication. Also, guidelines recommend urine drug screening to monitor prescribed substance and issues of abuse, addiction or poor pain control. There is no documentation submitted that a urine drug screening was done. Thus, the request is non-certified. Further guidelines recommend slow tapering/weaning process for the individuals having long-term use of opioids due to the risk of withdrawal symptoms.

ZANAFLEX 4MG #60: Upheld

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

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

Decision rationale: As per CA MTUS guidelines, Zanaflex is a centrally acting alpha2-adrenergic agonist that is FDA approved for management of spasticity; unlabeled use for lower back pain. In this case, this patient has chronic lower back pain, restricted lumbar motion, decreased sensation in L5 dermatome, 5/5 strength in lower extremities, normal reflexes, and no documentation of muscle spasms on physical exam. Thus, the medical necessity for the muscle relaxer medication has not been established, and the request is non-certified.

AQUATIC THERAPY 12 SESSIONS: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic Therapy Page(s): 22-23.

Decision rationale: As per CA MTUS guidelines, aquatic therapy is "recommended as an optional form of exercise therapy, where available, as an alternative to land-based physical therapy. Aquatic therapy (including swimming) can minimize the effects of gravity, so it is specifically recommended where reduced weight bearing is desirable, for example extreme obesity." In this case, this patient is diagnosed with bilateral hip osteoarthritis; however, there is no documentation that the patient is unable to perform land-based physical therapy or inability to perform weight bearing activities. Thus, the request for 12 sessions of aquatic therapy is non-certified.