

Case Number:	CM14-0009310		
Date Assigned:	02/14/2014	Date of Injury:	12/04/2001
Decision Date:	07/24/2014	UR Denial Date:	01/06/2014
Priority:	Standard	Application Received:	01/23/2014

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 Tennessee. 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 58-year-old male who has filed a claim for bilateral shoulder impingement syndrome associated with an industrial injury date of December 04, 2001. Review of progress notes indicates worsening neck pain radiating to the bilateral shoulders; headaches; bilateral shoulder pain; low back pain radiating to bilateral lower extremities, associated with numbness in the right foot; and bilateral knee pain, with left knee swelling, locking, and giving way. Findings include decreased cervical range of motion; positive axial compression test; tenderness over the right acromioclavicular joint; and painful, restricted shoulder range of motion. There was tenderness of the lumbar region with decreased range of motion. Left shoulder MRI dated January 26, 2011 showed severe supraspinatus and infraspinatus tendinopathy with interval full thickness tear of the supraspinatus tendon; chronic degenerative tear of the superior labrum; advanced AC (Acromioclavicular) joint arthrosis and moderate subacromial/subdeltoid bursitis; and mild tendinopathy of the long head of the biceps tendon. Right knee MRI dated March 25, 2011 showed tricompartmental osteoarthritis, and post-operative change in the medial meniscus, although a tear or re-tear is suspected along the inferior surface of the posterior horn. Electrodiagnostic study of the upper extremities dated September 08, 2009 showed right C6 and bilateral C7 radiculopathies, and right carpal tunnel median neuropathy. Treatment to date has included opioids, NSAIDs, muscle relaxants, exercise program, Toradol injections, cervical fusion surgery, left and right knee arthroscopies, and left shoulder arthroscopy. Utilization review from January 06, 2014 denied the requests for Norco 10/325mg #100 with 3 refills, Lodine 500mg #30 with 3 refills, Ambien 10mg #30 with 3 refills, and Dexilant 60mg #30 with 3 refills. Reasons for denial were not submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

NORCO 10/325 MG #100 (AND 3 REFILLS): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS, CRITERIA FOR USE: ON-GOING MANAGEMENT Page(s): 78-82.

Decision rationale: As noted on page 78-82 of the CA MTUS 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. Patient has been on this medication since at least December 2009. There is no documentation regarding symptomatic improvement or objective functional benefits derived from this medication, and of periodic urine drug screens to monitor medication use. Also, additional refills are not indicated at this time without documentation of ongoing efficacy. Therefore, the request for Norco 10/325mg #100 with 3 refills was not medically necessary.

LODINE 500MG #60 (AND 3 REFILLS): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 71.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS (NONSTEROIDAL ANTI-INFLAMMATORY DRUGS) Page(s): 67-69.

Decision rationale: As stated on pages 67-69 of the California MTUS Chronic Pain Medical Treatment Guidelines, NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain and there is no evidence of long-term effectiveness for pain or function. Patient has been on this medication since at least December 2009. There is no documentation regarding symptomatic improvement or objective functional benefits derived from this medication. Therefore, the request for Lodine 500mg #60 with 3 refills was not medically necessary.

AMBIEN 10MG #30 (AND 3 REFILLS): 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, Zolpidem (Ambien).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) PAIN CHAPTER, AMBIEN (ZOLPIDEM TARTRATE).

Decision rationale: The CA MTUS does not address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, ODG was used instead. According to ODG, Ambien is approved for the short-term (usually two to six weeks) treatment of insomnia. There is also concern that they may increase pain and depression over the long-term. Patient has been on this medication since at least December 2009. However, there is no documentation of patient's sleep issues in recent progress notes. Also, this medication is not recommended for long-term use. Therefore, the request for Ambien 10mg #30 with 3 refills was not medically necessary.

DEXILANT 60MG #30 (AND 3 REFILLS): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI SYMPTOMS & CARDIOVASCULAR RISK Page(s): 68.

Decision rationale: According to page 68 of CA MTUS Chronic Pain Medical Treatment Guidelines, proton pump inhibitors are used in patients on NSAID therapy who are at risk for GI (Gastro Intestinal) events. Risk factors includes age more than 65; history of peptic ulcer, GI bleed, or perforation; concurrent use of ASA (Acetylsalicylic Acid) , corticosteroids, or anticoagulant; and high dose or multiple NSAID use. Use of PPI (Proton Pump Inhibitors) more than 1 year has been shown to increase the risk of hip fracture. Patient has been on this medication since at least January 2013. This patient has been diagnosed with gastroesophageal reflux in the past. However, the submitted documentation does not indicate patient's upper GI symptoms. Also, the request for NSAID has not been authorized in this patient. Therefore, the request for Dexilant 60mg #30 with 3 refills was not medically necessary.