

Case Number:	CM14-0128502		
Date Assigned:	09/29/2014	Date of Injury:	07/27/2011
Decision Date:	12/10/2014	UR Denial Date:	07/30/2014
Priority:	Standard	Application Received:	08/13/2014

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 Occupational Medicine and is licensed to practice in Iowa. 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 60 year-old male with a date of injury of 7/27/2011. A review of the medical documentation indicates that the patient is undergoing treatment for chronic neck, back, knee, and hand pain. Subjective complaints (6/3/2014) include pain in the neck, lower back, bilateral knees, and bilateral hands. Objective findings (6/3/2014) include spasms, pain with motion, decreased range of motion, and paraspinal tenderness in cervical and lumbar spinal region; positive Tinel's and Phalen's bilaterally; and medial/lateral joint line tenderness bilateral knees with swelling and positive McMurray's and Apley's on right. Diagnoses include cervical and lumbar disc bulge, bilateral carpal tunnel syndrome, and bilateral knee osteoarthritis. The patient has undergone studies to include MRI of the left knee in 2013, which showed osteoarthritis and medial meniscal tear; other imaging was not available for review. The patient has previously undergone medication treatment and knee injections; one note mentions previous chiropractic treatment and right knee surgeries in 2012 and 2013. A utilization review dated 7/30/2014 did not certify the request for Injection-Toradol, Injection-Dexamethasone, Injection-Depomedrol, Ambien 5mg #60, Protonix 20 mg #60, Soma 350 mg #60, and Percocet 10-325 mg #60.

IMR ISSUES, DECISIONS AND RATIONALES

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

Injection - Toradol 15mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Ketorolac Page(s): 72. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Ketorolac

Decision rationale: Ketorolac (Toradol) is an injectable NSAID pain medication. MTUS indicates that this medication is not indicated for chronic pain. ODG states that injection Ketorolac is recommended as an alternative option to corticosteroid or opioid therapy. All sources indicate that it is generally utilized for treatment of acute conditions. Similar standards should also to apply as other injections, including documentation of failure of conservative therapy (medication and physical methods), detailing of the level to be injected, and documentation of response. The treating physician does not clearly indicate which body part is to be injected, given that the patient has multiple pain complaints including both cervical and lumbar symptoms. There is no documentation of failed conservative therapy, as the patient is still on pain medication and there is no indication physical therapy was utilized. The injection also does not appear to be an alternative to corticosteroid or opioid therapy, as treating physician is also requesting refills of opioids and additional epidural steroid injections. The patient's pain is also of chronic nature. Therefore the request for Injection-Toradol 15 mg is not medically necessary at this time.

Injection Dexamethasone 10mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs) Page(s): 46. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Epidural steroid injections (ESIs)

Decision rationale: MTUS guidelines state that epidural steroid injections are recommended as an option for treatment of radicular pain. Epidural steroid injection can offer short term pain relief and use should be in conjunction with other rehab efforts, including continuing a home exercise program. Guidelines also state that failed response to conservative treatment should be detailed, and that a maximum of two injections should be performed, with the second used only if there is inadequate response to the first injection. The treating physician does not clearly indicate which body part is to be injected, given that the patient has multiple pain complaints including both cervical and lumbar symptoms. There is no documentation that indicates conservative therapy has failed or that other rehab efforts have been or are being utilized. There is also no evidence of radicular pain on exam. Therefore the request for Injection-Dexamethasone 10 mg is not medically necessary.

Injection Depo-medrol 80mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs) Page(s): 46. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Epidural steroid injections (ESIs)

Decision rationale: MTUS guidelines state that epidural steroid injections are recommended as an option for treatment of radicular pain. Epidural steroid injection can offer short term pain relief and use should be in conjunction with other rehab efforts, including continuing a home exercise program. Guidelines also state that failed response to conservative treatment should be detailed, and that a maximum of two injections should be performed, with the second used only if there is inadequate response to the first injection. The treating physician does not clearly indicate which body part is to be injected, given that the patient has multiple pain complaints including both cervical and lumbar symptoms. There is no documentation that indicates conservative therapy has failed or that other rehab efforts have been or are being utilized. There is also no evidence of radicular pain on exam. Therefore the request for Injection-Depomedrol 80 mg is not medically necessary.

Ambien 5mg #60: Upheld

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

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, Zolpidem, insomnia treatment

Decision rationale: Ambien (Zolpidem) is a short acting, non-benzodiazepine hypnotic, which is approved for short-term treatment of insomnia. MTUS does not provide recommendations on use of this medication. ODG states that Zolpidem is a prescription short acting non-benzodiazepine hypnotic, which is approved for short-term treatment of insomnia. Guidelines recommend teaching and practicing proper sleep hygiene prior to initiation of medication, to include diagnosis of the specific component of insomnia to be addressed. The treating physician has not provided any documentation of discussion of sleep hygiene, diagnosis of the sleep component at issue, response to prior first-line therapies, or the need for sleep medication. The patient appears to have been taking this medication for an extended period of time. There has been no documented discussion of the patient's sleep hygiene or additional information to justify use of the medication. There is minimal documentation relating to the current need to continue this therapy and its effectiveness. Therefore the request for Ambien 5 mg #60 is not medically necessary at this time.

Protonix 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 based on Non-MTUS Citation

Official Disability Guidelines (ODG) Pain (Chronic), NSAIDs, GI symptoms & cardiovascular risk

Decision rationale: Protonix (pantoprazole) is classified as a proton pump inhibitor (PPI). According to MTUS guidelines, this type of medication is recommended in patients at intermediate or high risk for gastrointestinal (GI) events and who have no cardiovascular disease. The guidelines provide criteria for risk stratification for gastrointestinal events. Risk factors include (1) age >65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID. Use of the medication is meant to serve as protection from GI issues. Other indications for use of this medication would be for primary GI disorders such as reflux disease. Long-term PPI use has significant side effects including increased risk of hip fracture. The medical documentation does not provide evidence of a primary GI disorder, bleeding, perforation, peptic ulcer, high dose NSAID, ASA use, or other GI risk factors. The only mention of an indication is "for relief of stomach upset". The treating physician does not provide any additional justification or indication for use of the medication. Therefore, the request for Protonix 20 mg #60 is not medically necessary at this time.

Is Soma 350mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for chronic pain, Antispasmodics, Muscle relaxants (for pain), Carisoprodol Page(s):. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Muscle Relaxants

Decision rationale: Soma (Carisoprodol) is a muscle relaxant class medication. According to MTUS guidelines, muscle relaxants are recommended for chronic pain for a short course of therapy for acute exacerbations. Muscle relaxants may be effective in reducing pain and muscle tension, but in most back pain cases they show no benefit beyond NSAIDs. Evidence indicates the greatest effect is seen in the first 4 days of treatment. MTUS also states that pain relief is generally temporary, and continued evaluation should include documentation improvement in function and increased activity. ODG also states that a short course of therapy is recommended, and that this medication should not be used with other agents. Both MTUS and ODG state that Soma is not recommended, due to the main effect of generalized sedation and treatment of anxiety and potential for abuse. The medical documentation indicates the patient has been on this medication for an extended period of time, exceeding the short-term recommendation for treatment length. The treating physician has not provided rationale for the extended use of this medication, and the documentation indicates that the patient continues to have pain and decreased functional status. The only potential indication is the documentation of muscle spasms, but it is unclear if these are acute in nature or if the medication is helping with these symptoms since they are still occurring despite ongoing therapy. The patient is also on other pain medication, which is not recommended. Therefore the request for Soma 350 mg #60 is not medically necessary.

Is Percocet 10-325 mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), Opioids

Decision rationale: Percocet is an opioid class pain medication. According to MTUS guidelines, opioids are indicated mainly for osteoarthritis only after first-line conservative options have failed, and should include clear improvement in pain and functional status for continued use. There is limited evidence to support long-term use for back or other musculoskeletal pain. MTUS also states that ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur and an improved response to treatment should be observed. MTUS recommends discontinuing therapy if there is no improvement in pain or function. ODG does not recommend the use of opioids for low back pain except for short use for severe cases, not to exceed two weeks. The medical documentation indicates the patient has been on this medication for an extended period of time, exceeding the two-week recommendation for treatment length. The treating physician has not provided rationale for the extended use of this medication, and does not include sufficient documentation regarding the reported pain over time or specific improvement while on this medication. The documentation indicates that the patient continues to have pain and decreased functional status with no improvement. Therefore, the request for Percocet 10-325 mg #60 is not medically necessary at this time.