MAXIMUS Federal Services

Case Number:	CM14-0150241		
Date Assigned:	09/19/2014	Date of Injury:	03/12/2001
Decision Date:	10/22/2014	UR Denial Date:	09/02/2014
Priority:	Standard	Application Received:	09/15/2014

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 Physical Medicine and Rehabilitation and is licensed to practice in Illinois. 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 injured worker is a 56-year-old female who reported an injury on 03/12/2001. The mechanism of injury was not provided. On 08/19/2014, the injured worker presented with persistent pain in the neck, back, right shoulder, and bilateral knees. Upon examination of the cervical spine, there was decreased range of motion with tenderness at the paraspinals and trapezius muscles bilaterally. There was a positive Spurling's on the left and a positive cervical compression test. There was 5/5 strength and decreased sensation 4/5 on the left C5 and C6. Examination of the lumbar spine revealed decreased range of motion with positive Kemp's sign bilaterally. There was a positive bilateral straight leg raise. There was decreased strength and sensation bilaterally at L4 and L5 and 2+ deep tendon reflexes at the patellar and Achilles tendons. The diagnoses were cervical disc herniation with left upper extremity radiculitis, worsening left sided cervical radiculopathy, lumbar spinal stenosis, right shoulder rotator cuff syndrome, right knee posttraumatic osteoarthritis, and left knee medial compartmental osteoarthritis, posttraumatic. Prior therapy included medications and a TENS unit. The provider recommended Anexsia/Hydrocodone, Ambien, diclofenac/Lidocaine cream, pain management treatment for cervical epidural steroid injection, and urine toxicology screen. The provider's rationale was not provided. The request for authorization form was not included in the medical documents for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective request for Anexsia/Hydrocodone/APAP 7.5/325mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for use Page(s): 78.

Decision rationale: The request for Anexsia/Hydrocodone/APAP 7.5/325 mg #60 is not medically necessary. The California MTUS Guidelines recommend the use of opioids for ongoing management of chronic pain. The guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should be evident. There is lack of evidence of an objective assessment of the injured worker's pain level, functional status, evaluation of risk for aberrant drug abuse behavior and side effects. The efficacy of the prior use of the medication was not provided. as such, the medical necessity has not been established.

Ambien 5mg #30: 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), Chronic Pain

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Ambien.

Decision rationale: The request for Ambien 5 mg #30 is not medically necessary. The Official Disability Guidelines state that Ambien is a prescription drug acting non benzodiazepine hypnotic which is approved for the short term use of 2 to 6 week treatment of insomnia. Proper sleep hygiene is critical to the individual with chronic pain and often is hard to obtain. Various medications may provide short term benefit. While sleeping pills, so-called minor tranquilizers, and anti anxiety agents are commonly prescribed in chronic pain, pain specialists rarely, if ever, recommend them for long term use. They can be habit forming, and they may impair function and memory more than opioid pain relievers. There is also concern that they may increase pain and depression over the long term. Cognitive behavioral therapy should be an important part of the injured workers treatment plan. The efficacy of the prior use of the medication was not provided. Additionally, the provider's request for Ambien 5 mg #30 exceeds the guideline recommendation for short term treatment. As such, the medical necessity has not been established.

Diclofenac/Lidocaine cream (3%/5%) 180mg: Upheld

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

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

Decision rationale: The request for diclofenac/lidocaine cream (3%/5%) 180 mg is not medically necessary. The California MTUS Guidelines state topical compounds are largely experimental in use with few randomized controlled trials to determine efficacy and safety. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least one drug that is not recommended is not recommended. There is lack of documentation that the injured worker has tried and failed an antidepressant or anticonvulsant. Additionally, topical NSAIDs are recommended for treatment of osteoarthritis and tendonitis for those joints amenable to topical treatment. The injured worker does not have a diagnosis congruent with the guideline recommendation for topical NSAIDs. As such, the medical necessity has not been established.

Pain management treatment for cervical epidural steroid injections: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 9 Shoulder Complaints, Chapter 10 Elbow Disorders (Revised 2007), Chapter 11 Forearm, Wrist, and Hand Complaints, Chapter 12 Low Back Complaints, Chapter 13 Knee Complaints, Chapter 14 Ankle and Foot Complaints,Chronic Pain Treatment Guidelines Epidural Steroid Injections.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injection Page(s): 46.

Decision rationale: The request for pain management treatment for cervical epidural steroid injections is not medically necessary. According to California MTUS Guidelines, an epidural steroid injection may be recommended to facilitate progress in more active treatment programs when there is radiculopathy documented by physical examination and/or corroborated by imaging studies and/or electrodiagnostic testing. Additionally, the documentation showed the injured worker was initially unresponsive to conservative care. Injections should be performed with the use of fluoroscopy for guidance and no more than 2 levels should be injected using transforaminal blocks. The documentation submitted for review noted decreased range of motion in the cervical spine with a positive compression test. There is a positive left sided Spurling's and decreased sensation to the C5 and C6. More information is needed on motor strength. Additionally, there is lack of documentation of radiculopathy and physical exam findings corroborating with imaging and/or electrodiagnostic testing. In addition, the documentation failed to show the injured worker would be participating in an active treatment program following the requested injection. The provider's request does not indicate the levels recommended for the requested injection in the request as submitted. As such, the medical necessity has not been established.

Urine toxicology screen: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Use of Urine Drug Testing

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Urine Drug Test Page(s): 43.

Decision rationale: The request for urine toxicology screen is not medically necessary. The California MTUS Guidelines recommend a urine drug test as an option to assess for the use or presence of illegal drugs. It may also be used in conjunction with therapeutic trial of opioids, for ongoing management and anticipating for risk or misuse and addiction. The documentation provided did not indicate the injured worker displayed any aberrant behaviors or drug seeking behaviors or whether the injured worker was suspected of illegal drug use. It is unclear when the last urine drug screen was performed. As such, the medical necessity has not been established.