

Case Number:	CM14-0028046		
Date Assigned:	06/16/2014	Date of Injury:	08/30/2003
Decision Date:	07/28/2014	UR Denial Date:	02/13/2014
Priority:	Standard	Application Received:	03/05/2014

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, has a subspecialty in Pain Medicine 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 injured worker is a 66 year old male who sustained an injury on 08/30/03. No specific mechanism of injury was noted. The injured worker was followed for ongoing complaints of chronic neck pain radiating to the right upper extremity. The injured worker was followed for pain management by [REDACTED]. Medication history was pertinent for muscle relaxers, anti-inflammatories, topical anti-inflammatory patches, Ambien, hydrocodone, and Lyrica. The clinical record on 12/02/13 noted ongoing complaints of neck pain impacting his ability to sleep. Pain scores were 8/10 on VAS. Physical examination findings noted tenderness to palpation at the cervico-occipital junction and over the occipital condyles. There was pain with any range of motion of the cervical spine. The injured worker described pain radiating with associated numbness and tingling in the upper extremities. This was less severe than the ongoing neck pain. Hydrocodone was continued at this visit. Follow up on 02/03/14 noted continuing complaints of neck pain and pain radiating to the shoulder. Pain scores remained unchanged. On physical examination there was limited range of motion in the cervical spine with flexion/extension very painful. Tension along the posterior cervical musculature was noted. Spurling's sign was reported as somewhat positive to the left. There was no evidence of myelopathy. Recommendations were for CT scans EMG and cervical injections. The injured worker was seen on 04/07/14. Symptoms were unchanged. The injured worker was utilizing Norco up to four to five times per day which allowed the injured worker to function. Pain scores were unchanged. On physical examination there was continued loss of range of motion in the cervical spine with almost zero flexion/extension. There was exquisite tenderness to palpation over the occipital condyles with spasm along the left trapezium and lower cervical posterior musculature. The injured worker had a steroid injection at the left occipital region. The requested Zolpidem 10mg #30, hydrocodone 10/325mg #30, Lyrica 75mg #90, ibuprofen 800mg #180, Amrix 1

15mg #120, Flector 1.3% transdermal patch, CT cervical spine, EMG left upper extremity, therapeutic bed, and cervical injections were non-certified by utilization review on 02/13/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

ZOLPIDEM TARTRATE 10 MG. QTY: 30: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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.

Decision rationale: In regards to the use of Zolpidem 10mg quantity 30, this reviewer would not have recommended this medication as medically necessary based on the clinical documentation provided for review and current evidence based guideline recommendations. The use of Zolpidem to address insomnia is recommended for a short term duration no more than 6 weeks per current evidence based guidelines. Furthermore, the FDA has recommended that dosing of Zolpidem be reduced from 10mg to 5mg due to adverse effects. The clinical documentation submitted for review does not provide any indications that the use of Zolpidem was effective in improving the claimant's overall functional condition. As such, this reviewer would not recommend this request as medically necessary.

HYDROCODONE-ACETAMINOPHEN 10/325 MG. QTY: 30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 80.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for Use Page(s): 88-89.

Decision rationale: In regards to the use of hydrocodone 10/325mg quantity 30, this reviewer would not have recommended this medication as medically necessary based on the clinical documentation provided for review and current evidence based guideline recommendations. The injured worker has been utilizing this medication over an extended period of time. Per current evidence based guidelines, the use of a short acting narcotic such as Norco can be considered an option in the treatment of moderate to severe musculoskeletal pain. The benefits obtained from short acting narcotics diminishes over time and guideline recommend that there be ongoing indications of functional benefit and pain reduction to support continuing use of this medication. Overall, there is insufficient evidence in the clinical literature that long term use of narcotic medications results in any functional improvement. The clinical documentation provided for review did not identify any particular functional improvement obtained with the ongoing use of Norco. No specific pain improvement was attributed to the use of this medication. The clinical documentation also did not include any compliance measures such as toxicology testing or long

term opiate risk assessments (COMM/SOAPP) to determine risk stratification for this claimant. This would be indicated for Norco given the long term use of this medication. As there is insufficient evidence to support the ongoing use of Norco, this reviewer would not have recommend this request as medically necessary.

LYRICA 75 MG. QTY: 90.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepileptics Page(s): 16-22.

Decision rationale: In regards to the request for Lyrica 75mg quantity 90, this reviewer would not have recommended this medication as medically necessary. There is no indication from the clinical records that this medication was effective for the ongoing complaints of neck pain and myofascial pain. Physical examination findings did not identify any clear evidence of neurological deficit to support neuropathic conditions that would require the use of an anticonvulsant. Although Lyrica is indicated as a first line medication in the treatment of neuropathic pain this is not substantiated by the medical records provided. Therefore this reviewer would not have recommended this medication as medically necessary.

IBUPROFEN 800 MG. QTY: 180.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Non-Steroidal Anti-Inflammatory Drugs Page(s): 67, 68.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-68.

Decision rationale: In regards to the use of ibuprofen 800mg quantity 180, this reviewer would not have recommended this medication as medically necessary based on the clinical documentatin provided for review and current evidence based guideline recommendations. The chronic use of prescription NSAIDs is not recommended by current evidence based guidelines as there is limited evidence regarding their efficacy as compared to standard over-the-counter medications for pain such as Tylenol. Per guidelines, NSAIDs can be considered for the treatment of acute musculoskeletal pain secondary to injury or flare ups of chronic pain. There is no indication that the use of NSAIDs in this case is for recent exacerbations of the claimant's known chronic pain. As such, the injured worker could have reasonably transitioned to an over-the-counter medication for pain.

AMRIX 15 MG. QTY: 120.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63, 64.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63-67.

Decision rationale: In regards to the use of Amrix 15mg quantity 120, this reviewer would not have recommended this medication as medically necessary based on the clinical documentation provided for review and current evidence based guideline recommendations. The chronic use of muscle relaxers is not recommended by current evidence based guidelines. At most, muscle relaxers are recommended for short term use only. The efficacy of chronic muscle relaxer use is not established in the clinical literature. There is no indication from the clinical reports that there had been any recent exacerbation of chronic pain or any evidence of a recent acute injury. Therefore, this reviewer would not have recommended this medication as medically necessary.

FLECTOR 1.3% TRANSDERMAL PATCH QTY: 1.00: Upheld

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

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

Decision rationale: In regards to the request for Flector patches 1.3% quantity 1, this reviewer would not have recommended this medication as medically necessary. Flector patches are indicated as an option to treat musculoskeletal pain that has failed oral anti-inflammatory use or if oral anti-inflammatories are not tolerated or otherwise contraindicated. In this case the injured worker was utilizing oral anti-inflammatories with no evidence of side effect. There was no indication of any contraindication for oral medications. As such this reviewer would not have recommended this medication as medically necessary.

COMPUTED TOMOGRAPHY SCAN CERVICAL SPINE QTY: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 182.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179.

Decision rationale: In regards to the request for CT studies of the cervical spine, the clinical documentation submitted for review did not identify any red flag findings on physical examination or evidence of progressive/severe neurological deficit that would support imaging of the cervical spine. Furthermore there was no discussion regarding contraindications to MRI of the cervical spine which would be considered the gold standard. As such this reviewer would not have recommended certification for this request.

ELECTROMYOGRAM (EMG) LEFT UPPER EXTREMITY (UE) QTY: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179.

Decision rationale: In regards to the request for EMG studies of the left upper extremity, this reviewer would not have recommended this proceed this test as medically necessary. The injured worker did not present with any clear progressive or severe neurological deficits affecting the left upper extremity that would support EMG. No prior imaging of the cervical spine was available for review indicating evidence of possible neurocompressive findings that would support EMG to define possible radiculopathy. Given the date of injury which is now more than 10 years old it is unclear how EMG would have provided any additional information to help guide course of treatment. Therefore this reviewer would not have recommended this request as medically necessary.

THERAPEUTIC BED QTY: 1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Mattress selection.

Decision rationale: In regards to the request for a therapeutic bed, this request would not have been recommended as medically necessary. There mattress selection is highly subjective in nature and there is insufficient evidence in the clinical literature establishing that any one particular type of med bed or mattress results in functional improvement or decrease in pain to or decrease in pain secondary to musculoskeletal conditions or myofascial pain syndrome. Therefore this reviewer would not have recommended this request as medically necessary.

CERVICAL INJECTIONS QTY: 1: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173-175.

Decision rationale: In regards to the request for cervical injections, this reviewer would not have recommended this request as medically necessary. It is unclear what type of cervical injections are being recommended for the injured worker or what outcomes are being expected from cervical injections. The most recent reports did not clarify the request. Given the insufficient information regarding this request and generic nature of the request this reviewer would not have recommended this procedure as medically necessary.