

Case Number:	CM14-0038589		
Date Assigned:	07/30/2014	Date of Injury:	12/26/2001
Decision Date:	09/11/2014	UR Denial Date:	03/13/2014
Priority:	Standard	Application Received:	04/02/2014

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 Nevada. 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 records presented for review indicate that this 55 year old individual was reportedly injured on December 26, 2001. The mechanism of injury is undisclosed. The most recent progress note, dated February 14, 2014, indicates that there are ongoing complaints of severe neck and bilateral shoulder pain. Numbness and tingling are described in both upper extremities. Subjectively, there is a reported efficacy with the medications. The physical examination demonstrated cervical flexion extension 10 degrees with muscle spasm and tenderness to palpation. Shoulder flexion extension was noted to be 60 degrees each, again associated with tenderness over the trapezial musculature. A normal motor and deep tendon reflexes are noted. Decreased sensation is noted in both hands. Diagnostic imaging studies were not reviewed. Previous treatment includes multiple surgeries, multiple medications, and pain management techniques. A request was made for multiple medications and was not certified in the preauthorization process on March 13, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Valium 10mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 23,82-88, 118-120. Decision based on Non-MTUS Citation Official Disability Guidelines Pain Chapter - Formulary.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24 of 127.

Decision rationale: This medication is a benzodiazepine which is not recommended for long term use as the efficacy is unproven and there is a risk of dependence. The most recent progress notes presented for review do not indicate that there has been any improvement in the muscle spasm, the complaints associated muscle spasm, or the physical examination related to this symptom. As such, the medical necessity for the continued used medication has not been objectified in the progress notes reviewed. Therefore, this request is not medically necessary.

Norco 10/325mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 82-88, 91.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-78 of 127.

Decision rationale: Norco (Hydrocodone/acetaminophen) is a short acting opioid combined with acetaminophen. California Medical Treatment Utilization Schedule (MTUS) supports short acting opiates for the short term management of moderate to severe breakthrough pain. Management of opiate medications should include the lowest possible dose to improve pain and function, as well as the ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects. The injured employee has chronic pain; however, there is no clinical documentation of improvement in their pain or function with the current regimen. As such, based on the medical records presented for review and noting the lack of narrative establishing the efficacy of this preparation, this request is not considered medically necessary.

Prilosec 20mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 68. Decision based on Non-MTUS Citation Official Disability Guidelines Pain Chapter Formulary.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68 of 127.

Decision rationale: Prilosec (Omeprazole) is a proton pump inhibitor useful for the treatment of gastroesophageal reflux disease (GERD) and is considered a gastric protectant for individuals utilizing nonsteroidal antiinflammatory medications. There are numerous proton pump inhibitors available over the counter without a prescription. Gastritis has not been documented as a diagnosis (or recurrent symptom). Therefore, the use of this medication is not medically necessary at this time when taking note of the minimal medical records presented for review. Therefore, this request is not medically necessary.

Fioricet #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 23 of 127.

Decision rationale: The progress notes presented for review over the last several months do not indicate any improvement in the symptomology, decrease in the ongoing complaints, or that there is any demonstration of efficacy or utility. Furthermore, as noted in the Medical Treatment Utilization Schedule (MTUS), barbiturate containing analgesic agents are not recommended for chronic pain. Therefore, there is no clinical indication of the medical necessity for this preparation.

Topical Cream 30mgFlurbiprofen 25% 120gm tube: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Creams Page(s): 118.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113 of 127.

Decision rationale: Medical Treatment Utilization Schedule (MTUS) guidelines state that topical analgesics are largely experimental and that any compound product that contains at least one drug (or drug class) that is not recommended is not recommended. In this case, the topical nonsteroidal preparation is not warranted. Additionally, topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is no discussion presented about trials of antidepressants and anticonvulsants indications. As such, this request is not medically necessary based on the limited progress of presented for review.

Topical Cream 30gm Cyclobenzaprine 10%-Tramadol 10% 120gm tube: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113 of 127.

Decision rationale: Medical Treatment Utilization Schedule (MTUS) guidelines state that topical analgesics are largely experimental and that any compound product that contains at least one drug (or drug class) that is not recommended is not recommended. In this case, the topical muscle relaxant Cyclobenzaprine is not warranted. Additionally, topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is no discussion presented about trials of antidepressants and anticonvulsants

indications. As such, this request is not considered medically necessary based on the limited progress presented for review.