

Case Number:	CM14-0084182		
Date Assigned:	08/06/2014	Date of Injury:	06/10/2008
Decision Date:	09/25/2014	UR Denial Date:	05/15/2014
Priority:	Standard	Application Received:	06/03/2014

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 & Rehabilitation, 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 expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records: Medical records reflect the claimant is a 54 year old female who sustained a work injury on 6-10-08. On 4-7-14, the claimant has a diagnosis of severe cervical stenosis. The claimant was seen for medication renewal. She reports ongoing pain with pain as 9/10. She reports her symptoms have remained the same. On exam, she ambulates with a normal heel to toe gait. The claimant had tenderness to palpation at the cervical spine, with decreased range of motion of the neck and upper extremities. Motor testing showed no focal deficits, DTR were 2 bilaterally.

IMR ISSUES, DECISIONS AND RATIONALES

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

Thermacare Mis Back / Hip Day Supply: 34 Qty: 34 Refills: 0: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) cervical spine chapter heat/cold applications.

Decision rationale: ODG reflects that heat/cold applications are recommended. Insufficient testing exists to determine the effectiveness (if any) of heat/cold applications in treating mechanical neck disorders, though due to the relative ease and lack of adverse effects, local applications of cold packs may be applied during first few days of symptoms followed by applications of heat packs to suit patient. There is an absence in current evidence based medicine to support that specialized equipment or prescription is needed for the application of heat. Therefore, the medical necessity of this request is not established. Additionally, no documentation of functional improvement is provided with the application of heat in this case. Therefore, this request is not medically necessary.

Voltaren Gel 1% Day Supply: 5 QTY: 100 Refills: 0: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics: Voltaren Gel 1% (diclofenac).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines topical analgesics Page(s): 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain chapter - topical analgesics.

Decision rationale: Chronic Pain Medical Treatment Guidelines as well as ODG reflect that these medications are largely experimental in use with few randomized controlled trials to determine efficacy or safety. The medication is primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is an absence in documentation noting that this claimant cannot tolerate oral medications or that she has failed first line of treatment. Therefore this request is not medically necessary.

Omeprazole CAP 20mg Day Supply: 30 Qty: 30 Refills: 0: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs and GI Risks.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: US National Library of medicine.

Decision rationale: Prescription omeprazole is used alone or with other medications to treat gastroesophageal reflux disease (GERD), a condition in which backward flow of acid from the stomach causes heartburn and possible injury of the esophagus (the tube between the throat and stomach). Prescription omeprazole is used to treat the symptoms of GERD, allow the esophagus to heal, and prevent further damage to the esophagus. Prescription omeprazole is also used to treat ulcers (sores in the lining of the stomach or intestine) and it is also used with other medications to treat and prevent the return of ulcers caused by a certain type of bacteria (*H. pylori*). Nonprescription (over-the-counter) Omeprazole is used to treat frequent heartburn (heartburn occurs at least 2 or more days a week). Omeprazole is in a class of medications called proton-pump inhibitors. It works by decreasing the amount of acid made in the stomach. There is an absence in documentation noting that this claimant has GI effects secondary to the

medications provided or that she is a high risk patient for GI development. Therefore, this request is not medically necessary.

Hydrocodone /APAP Tab 10-325MG Day Supply: 30 Qty: 60 Refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Ongoing Managements, Hydrocodone / Acetaminophen.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines opiodis Page(s): 74-96. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) pain chapter - opioids.

Decision rationale: Chronic Pain Medical Treatment Guidelines as well as ODG notes that ongoing use of opioids require ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Information from family members or other caregivers should be considered in determining the patient's response to treatment. The 4 A's for Ongoing Monitoring: Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non-adherent) drug-related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors). There is an absence in documentation noting that the claimant has functional improvement with this medication. The claimant reports she is the same with pain rated as 9/10. There is absence in documentation with quantification if functional improvement, psychosocial functioning. Therefore, this request is not medically necessary.

Zolpidem Tab 5mg Day Supply: 30 Qty: 60 Refills: 0: 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), Mental Illness and Stress 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 - Zolpidem.

Decision rationale: ODG does not support the long term use of this medication. Zolpidem is a prescription short-acting non-benzodiazepine hypnotic, which is approved for the short-term (usually two to six weeks) treatment of insomnia. This claimant sleep pattern has not been discussed or that the diagnosis of insomnia has been established. Therefore, this request is not medically necessary.

Carisoprodol Tab 350mg Day Supply: 30 Qty: 60 Refills 0: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain: Carisoprodol (Soma).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines muscle relaxants Page(s): 63-67. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain chapter - muscle relaxants.

Decision rationale: Chronic Pain Medical Treatment Guidelines as well as ODG does not support the long term use of muscle relaxants. There are no extenuating circumstances to support the long term use of this medication in this case. There is an absence in documentation noting muscle spasms. Therefore, this request is not medically necessary.