

Case Number:	CM14-0124992		
Date Assigned:	09/16/2014	Date of Injury:	10/13/2011
Decision Date:	03/19/2015	UR Denial Date:	08/01/2014
Priority:	Standard	Application Received:	08/07/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California, New York, Florida

Certification(s)/Specialty: Internal Medicine, Pulmonary Disease, Critical Care Medicine

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 57-year-old female who reported injury on 10/13/2011. The mechanism of injury was the injured worker was kicked and pushed against the wall by an agitated student. Prior treatment included a lumbar medial branch block radiofrequency rhizotomy on the left and the right and lumbar medial branch blocks as well as diagnostic studies and medications. Other therapies included physical therapy. The surgical history included a right total knee arthroplasty and rotator cuff repair. The documentation of 07/30/2014 revealed the injured worker's current medications included Norco, Cymbalta, Lidoderm, Xanax, Voltaren gel, Celebrex, Ambien, tizanidine, and Wellbutrin. The injured worker included the right shoulder pain had improved since rotator cuff repair. The physical examination revealed the injured worker had a tender right upper trapezius. The injured worker had a mildly painful right shoulder with limited flexion and shoulder abduction. The lower extremity deep tendon reflexes were within normal limits. The sensory examination was within normal limits and the strength was 5/5. The diagnoses included right shoulder pain and function improved status post rotator cuff repair, right knee pain and range of motion improved status post total knee replacement. The treatment plan included alprazolam 0.5 mg #30 one tablet 3 times a day, Celebrex 200 mg #30 one refill 1 capsule daily, Cymbalta 60 mg capsules 1 capsule daily, hydrocodone/acetaminophen 10/325 mg quantity 240 one tablet 1-2 by mouth every 4-6 hours prn max 8 per day, Lidoderm 5% patches #60 twelve hours on/12 hours off, tizanidine 4 mg tablets 1 refill 1 tablet twice a day, Voltaren 1% gel 1 refill take 4.03 topical grams 4 times per day, Wellbutrin SR 100 mg tablets extended release #60 1 tablet twice a day, and zolpidem 10 mg 30 days dispense 30 tablets 1 refill 1 tablet

at bedtime. The injured worker was noted to be taking these medications since at least 06/04/2014. Other therapies included psychological counseling. The most recent documentation was dated 10/23/2014, and revealed the injured worker complained of pain everywhere after waking up cold the other night on a previous night. The physical examination remained the same. The diagnoses remained the same. The medications prescribed remained the same. There was no Request for Authorization submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Alprazolam 0.5mg Qty# 90: Upheld

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

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

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines do not recommend the use of benzodiazepines as a treatment for injured workers with chronic pain for longer than 4 weeks due to the high risk of psychological and physiological dependence. The clinical documentation submitted for review indicated the injured worker had utilized the medication for an extended duration of time. There was a lack of documentation of objective functional benefit received from the medication. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for alprazolam 0.5 mg quantity 90 is not medically necessary.

Hydrocodone/APAP 10/325mg Qty#240: 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; ongoing management, Page(s): 60; 78.

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines recommend opiates for the treatment of chronic pain. There should be documentation of objective functional improvement, an objective decrease in pain, and documentation the injured worker is being monitored for aberrant drug behavior and side effects. The clinical documentation submitted for review failed to meet the above criteria. There was a lack of documentation of objective functional benefit, an objective decrease in pain and documentation the injured worker is being monitor for aberrant drug behavior and side effects. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for hydrocodone/APAP 10/325 mg quantity 240 is not medically necessary.

Lidoderm patch Qty#60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm Page(s): 56, 57.

Decision rationale: The California Medical Treatment Utilization Schedule guidelines indicate that Lidoderm patches may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. The clinical documentation submitted for review failed to indicate the injured worker had neuropathic pain. There was a lack of documentation of a trial and failure of a first line therapy. The request as submitted failed to indicate the frequency for the requested medication. The documentation indicated the injured worker had utilized the medication. There was a lack of documented efficacy for the requested medication. The request as submitted failed to indicate the body part to be treated and the frequency for the requested medication. Given the above, the request for Lidoderm patch #60 is not medically necessary.

Tizanidine 4mg Qty#60: Upheld

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

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

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines recommend muscle relaxants as a second line option for the short term treatment of acute low back pain and their use is recommended for less than 3 weeks. There should be documentation of objective functional improvement. The clinical documentation submitted for review indicated the injured worker had utilized the medication for an extended duration of time, and there was a lack of documentation of objective functional improvement. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Tizanidine 4 mg quantity 60 is not medically necessary.

Voltaren gel 1%: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Voltaren Gel Page(s): 112.

Decision rationale: The California Medical Treatment Utilization Schedule guidelines indicate Voltaren Gel 1% (diclofenac) is an FDA-approved agent indicated for relief of osteoarthritis pain in joints that lends themselves to topical treatment such as the ankle, elbow, foot, hand, knee, and wrist. It has not been evaluated for treatment of the spine, hip or shoulder. Maximum dose should not exceed 32 g per day (8 g per joint per day in the upper extremity and 16 g per joint per day in the lower extremity). The clinical documentation submitted for review failed to indicate the body part to be treated. There was a lack of documentation of objective functional improvement. Additionally, the request as submitted failed to indicate the frequency and the quantity as well as the body part to be treated with the Voltaren gel. The injured worker had utilized the medication for an extended duration of time, and there was a lack of documentation of an objective decrease in pain and objective functional improvement. Given the above, the request for Voltaren gel 1% is not medically necessary.

Zolpidem 10mg Qty#30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITIES 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

Decision rationale: The Official Disability Guidelines indicate that Zolpidem is not recommended for more than 10 days. There was a lack of documentation of objective functional benefit that was received with the medication. The injured worker was noted to be utilizing the medication for an extended duration of time. There was a lack of documentation of exceptional factors to warrant non-adherence to guideline recommendations. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Zolpidem 10 mg quantity 30 is not medically necessary.