

Case Number:	CM14-0189695		
Date Assigned:	11/20/2014	Date of Injury:	09/01/1998
Decision Date:	01/08/2015	UR Denial Date:	10/27/2014
Priority:	Standard	Application Received:	11/13/2014

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 Occupational Medicine, and is licensed to practice in California. 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:

Injured worker is a male with date of injury 9/1/1998. Per interventional pain management follow-up evaluation report dated 9/25/2014, the injured worker complains of cervical spine and lumbar spine pain that is constant and severe, which he rates at 9/10. He notes that the pain has increased since his last visit. He states that he has no medications for two months. Cervical spine examination reveals tenderness to palpation in the paraspinal muscles bilaterally. Range of motion is flexion 15 degrees, extension 30 degrees, right lateral flexion 20 degrees, left lateral flexion is less than 10 degrees, right lateral rotation 50 degrees, and left lateral rotation 60 degrees. Lumbar spine examination reveals tenderness to palpation in the paraspinal muscles bilaterally. Range of motion is lateral bending g 20 degrees bilaterally, flexion 40 degrees, and extension 10 degrees. Sensation is within normal limits at L1-S1, and motor strength is 4+/5 for right L4-S1 myotomes, and 5/5 for right L2, L3 and left L2-S1 myotomes. Knee and ankle reflexes are 2+ bilaterally. Diagnoses include 1) status post anterior cervical decompression and fusion at C4 to C7 2) arthrosis at C4-C5 and C5-C6 3) degenerative disc disease and facet disease on multiple levels in the lumbar spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ambien 12.5mg: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Pain (updated 10/06/14) 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, Insomnia section

Decision rationale: The MTUS Guidelines do not address the use of Zolpidem. Per the Official Disability Guidelines, pharmacological agents should only be used for insomnia management after careful evaluation of potential causes of sleep disturbance. Failure of sleep disturbance to resolve in a 7 to 10 day period may indicate a psychiatric and/or medical illness. Primary insomnia is generally addressed pharmacologically whereas secondary insomnia may be treated with pharmacological and/or psychological measures. Zolpidem reduces sleep latency and is indicated for the short-term treatment (7-10 days) of insomnia with difficulty of sleep onset and/or sleep maintenance. Adults who use Zolpidem have a greater than 3-fold increased risk for early death. Due to adverse effects, FDA now requires lower doses for Zolpidem. Chronic use of Ambien is not recommended. This request also does not specify the number of tablets to be dispensed, or the frequency of use. Medical necessity of this request has not been established. The dose that is being prescribed is also noted to be high without a rationale provided addressing this dosing. The request for Ambien 12.5 mg is determined to not be medically necessary.

Norco 10/325mg #180: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids section, Weaning of Medications section Page(s): 74-95, 124.

Decision rationale: The MTUS Guidelines do not recommend the use of opioid pain medications, in general, for the management of chronic pain. There is guidance for the rare instance where opioids are needed in maintenance therapy, but the emphasis should remain on non-opioid pain medications and active therapy. Long-term use may be appropriate if the patient is showing measurable functional improvement and reduction in pain in the absence of non-compliance. Functional improvement is defined by either significant improvement in activities of daily living or a reduction in work restriction as measured during the history and physical exam. The clinical reports do not address the efficacy of Norco in terms of objective functional improvement or pain reduction. Medical necessity for continued treatment with Norco has not been established. It is not recommended to discontinue opioid treatment abruptly, as weaning of medications is necessary to avoid withdrawal symptoms when opioids have been used chronically. This request however is not for a weaning treatment, but to continue treatment.

Biofreeze: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics section Page(s): 111, 112. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back chapter, Biofreeze Cryotherapy Gel section

Decision rationale: The MTUS Guidelines recommend the use of topical analgesics as long as the drug or drug class is recommended. Menthol is not addressed by the MTUS Guidelines, but it is often included in formulations of anesthetic agents. It induces tingling and cooling sensations when applied topically. Menthol induces analgesia through calcium channel-blocking actions, as well as binding to kappa-opioid receptors. Menthol is also an effective topical permeation enhancer for water-soluble drugs. There are reports of negative effects from high doses of menthol such as 40% preparations. The ODG recommends the use of Biofreeze as an optional form of cryotherapy for acute pain. The request for Biofreeze does not include the amount of to be dispensed, the frequency of use or number of refills. The requesting physician does not report that efficacy of Biofreeze with prior use. Medical necessity has not been established for this request despite the guideline support for its use. The request for Biofreeze is determined to not be medically necessary.

MRI lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 297, 303, 304, 309.

Decision rationale: The MTUS Guidelines do not recommend the routine use of MRI with low back complaints. MRI should be reserved for cases where there is physiologic evidence that tissue insult or nerve impairment exists, and the MRI is used to determine the specific cause. MRI is recommended if there is concern for spinal stenosis, cauda equine, tumor, infection or fracture is strongly suspected, and x-rays are negative. The requesting physician explains that the injured worker should have new MRIs, but is deferring to the injured worker's new pain management doctor. The requesting physician explains that the injured worker lives two hours away, so care is being transferred to a pain management doctor that is closer. There is no explanation of why a new MRI is indicated now and there are no red flags reported. Medical necessity of this request has not been established. The request for MRI lumbar spine is determined to not be medically necessary.

MRI cervical spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck & Upper Back (updated 08/04/14)

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

Decision rationale: Per the MTUS Guidelines, if physiologic evidence indicates tissue insult or nerve impairment, an MRI may be necessary. Other criteria for special studies are also not met, such as emergence of a red flag, failure to progress in a strengthening program intended to avoid surgery, and clarification of the anatomy prior to an invasive procedure. The requesting physician explains that the injured worker should have new MRIs, but is deferring to the injured worker's new pain management doctor. The requesting physician explains that the injured worker lives two hours away, so care is being transferred to a pain management doctor that is closer. There is no explanation of why a new MRI is indicated now and there are no red flags reported. Medical necessity of this request has not been established. The request for MRI cervical spine is determined to not be medically necessary.