

Case Number:	CM15-0164233		
Date Assigned:	09/01/2015	Date of Injury:	02/27/2005
Decision Date:	10/27/2015	UR Denial Date:	07/31/2015
Priority:	Standard	Application Received:	08/21/2015

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

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 64 year old female who sustained an injury on 2-27-05. Diagnoses include chronic pain other; lumbar disc displacement; lumbar radiculopathy; bilateral knee pain. Transforaminal epidural steroid inject left L4-S1 was performed on 7-14-14 and she reported 50-80% improvement. The 6-11-15 examination reports she has neck pain that is aggravated by activity and walking; low back that radiates down the bilateral lower extremities and bilaterally in the knees. The pain is rated 7-8 out of 10 with medications and the pain is unchanged since her last visit. Medications and acupuncture were helpful and reports moderately improved due to this therapy. Prescribed medications included Glucosamine, Chondroitin 500-400 mg; Fenoprofen Calcium 400 mg cap take 1 three times a day; Tramadol Hcl 50 mg; Cidaflex 500 mg; Eszopiclone 2 mg. 1 at bedtime as needed for insomnia; Omeprazole Dr 20 mg. Due to her increased acute increase in pain a Toradol injection with B12 was given; Toradol 60 mg with B12 1,000 intramuscularly. MRI's of lumbar spine were performed on 8-7-10. Limitations of activities of daily living include ambulation; hand function; and sleep. On 7-19-15 examination reports she received acupuncture and medication and reports moderate improvement due to this therapy. Notes indicate that the patient's pain is 10/10 without medication. The patient states can be and is causing sleepwalking. The patient states that she needs home care "due to decreased ability to do daily activities." The note goes on to state that the patient has failed more conservative treatment modalities for sleep disturbance. Functional abilities improved include: ability to attend church, brushing teeth; concentrating; cooking; sitting; standing and washing dishes. Due to ongoing functional limitations a request was made for initial home care assistance

evaluation for 2 hours per day for 5 days; home exercise program; weight loss program. Current requested treatments home care assistance evaluation, 2 hours per day 5 days per week; Eszopiclone 2 mg, 1 every day as needed #30; Glucosamine 500,400 mg 1 by mouth every day #30; Omeprazole DR 20 mg, 1 by mouth every day #30; Fenoprofen Calcium 400 mg, 1 by mouth three times a day #90; Lidocaine ointment 5 %, apply to affected areas twice a day-three times a day 120 grams #1. The utilization review on 7-31-15 did not approve any of the requested treatments.

IMR ISSUES, DECISIONS AND RATIONALES

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

Home care assistance evaluation, 2 hours per day 5 days per week: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back, Home Health Services.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Home health services.

Decision rationale: Regarding the request for Home care assistance evaluation, 2 hours per day 5 days per week, California MTUS states that home health services are recommended only for otherwise recommended medical treatment for patients who are homebound, and medical treatment does not include homemaker services like shopping, cleaning, and laundry, and personal care given by home health aides like bathing, dressing, and using the bathroom when this is the only care needed. Within the documentation available for review, there is no documentation that the patient is homebound and in need of specialized home care (such as skilled nursing care, physical, occupational, or speech-language therapy) in addition to home health care. In the absence of such documentation, the currently requested Home care assistance evaluation, 2 hours per day 5 days per week is not medically necessary.

Omeprazole Dr 20mg, 1 PO QD #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Proton Pump Inhibitors (PPIs).

Decision rationale: Regarding the request for omeprazole (Prilosec), California MTUS states that proton pump inhibitors are appropriate for the treatment of dyspepsia secondary to NSAID therapy or for patients at risk for gastrointestinal events with NSAID use. Within the documentation available for review, there is no indication that the patient has complaints of dyspepsia secondary to NSAID use, a risk for gastrointestinal events with NSAID use, or another indication for this medication. In light of the above issues, the currently requested omeprazole (Prilosec) is not medically necessary.

Eszopiclone 2mg, 1QD PRN #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Chapter, Insomnia Treatment, Eszopiclone (Lunesta).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain, Sleep Medication, Insomnia treatment.

Decision rationale: Regarding the request for Lunesta (eszopiclone), California MTUS guidelines are silent regarding the use of sedative hypnotic agents. ODG recommends the short-term use (usually two to six weeks) of pharmacological agents only after careful evaluation of potential causes of sleep disturbance. They go on to state the failure of sleep disturbances to resolve in 7 to 10 days, may indicate a psychiatric or medical illness. Within the documentation available for review, there are no subjective complaints of insomnia, no discussion regarding how frequently the insomnia complaints occur or how long they have been occurring, no statement indicating what behavioral treatments have been attempted for the condition of insomnia, and no statement indicating how the patient has responded to Lunesta treatment. Finally, there is no indication that Lunesta is being used for short term use as recommended by guidelines. In the absence of such documentation, the currently requested Lunesta (eszopiclone) is not medically necessary.

Fenoprofen Calcium Cap 400mg, 1 PO Tab TID #90: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steroidal anti-inflammatory drugs), NSAIDs, GI symptoms & cardiovascular risk, NSAIDs, hypertension and renal function, NSAIDs, specific drug list & adverse effects.

Decision rationale: Regarding the request for Fenoprofen Calcium Cap 400mg, 1 PO Tab TID #90, Chronic Pain Medical Treatment Guidelines state that NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Within the documentation available for review, it appears that the patient's medications are reducing her pain. It is acknowledged, that there should be better documentation of specific analgesic benefit as a result of this medicine as well as functional improvement as a result of this medicine. However, a one-month prescription of medication as requested here, should allow the requesting physician time to better document those items. As such, the currently requested Fenoprofen Calcium Cap 400mg, 1 PO Tab TID #90 is medically necessary.

Glucosamine 500/400mg, 1 PO QD #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Glucosamine (and Chondroitin Sulfate).

Decision rationale: Regarding the request for glucosamine, CA MTUS states that glucosamine and chondroitin is recommended as an option given its low risk, in patients with moderate arthritis pain, especially for knee osteoarthritis. Within the documentation available for review, there is no indication of subjective/objective/imaging findings consistent with osteoarthritis for which the use of glucosamine would be supported by the CA MTUS. In the absence of such documentation, the currently requested glucosamine is not medically necessary.

Lidocaine ointment 5%, BID-TID 120 grams #1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: Regarding request for Lidocaine ointment, Chronic Pain Medical Treatment Guidelines recommend the use of topical lidocaine for localized peripheral pain after there has been evidence of a trial of the 1st line therapy such as tri-cyclic antidepressants, SNRIs, or antiepileptic drugs. Guidelines go on to state that no commercially approved topical formulations of lidocaine cream, lotion, or gel are indicated for neuropathic pain. Within the documentation available for review, there is no indication that the patient has failed first-line therapy recommendations. Furthermore, guidelines do not support the use of topical lidocaine preparations which are not in patch form. As such, the currently requested Lidocaine ointment is not medically necessary.