

Case Number:	CM15-0183344		
Date Assigned:	09/24/2015	Date of Injury:	08/15/2009
Decision Date:	11/18/2015	UR Denial Date:	09/16/2015
Priority:	Standard	Application Received:	09/17/2015

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: Preventive Medicine, Occupational 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 92 year old male, who sustained an industrial injury on 8-15-2009. The injured worker was diagnosed as having chronic pain syndrome, lumbar radiculopathy, lumbar stenosis, osteoarthritis localized, lower leg, sprain-strain elbow-forearm, and chondromalacia patella. Treatment to date has included diagnostics, physical therapy, bilateral knee surgeries, right elbow surgery, medial branch block on 6-29-2015, and medications. Currently (9-08-2015), the injured worker complains of pain in his neck, mid and low back, right elbow, and bilateral knees. He stated that his neck pain radiated down both shoulders to his hands and low back pain radiated down both legs. He reported numbness and tingling to both upper and lower extremities and reported "imbalance" with both knees, stating that his knees lock when he tried to walk. Pain was rated 5 out of 10 with medication and 9-10 without (rated 6 out of 10 with medication and 9-10 of 10 without on 8-10-2015). Medications included Docusate, Gabapentin, Omeprazole, Oxycontin, Percocet, Polyethylene glycol, Voltaren gel 1%-2gms four times daily, and Zolpidem 10mg nightly. He reported that Voltaren gel helped alleviate his pain and Zolpidem helped him sleep. He reported no changes since his last visit and reported that by taking medications he was able to walk more, self-care, and go grocery shopping. Objective findings included "decreased" range of motion in the right elbow due to pain, "moderate" tenderness to palpation right olecranon, "severe" tenderness to palpation bilateral lumbar paraspinal musculature with positive twitch response, negative straight leg raise bilaterally, "moderate" pain with lumbar extension, and "mild" tenderness to palpation left lower lumbar facet joints. His work status was retired. Per the Agreed Medical Evaluation report (7-24-2015),

future medical care should include treatment for flare-ups in his condition, physician visits, medications, physical therapy, "may require further surgery in the right upper extremity, particularly for a carpal tunnel release", and "he was a candidate for revision total knee replacements bilaterally given the flexion instability present". Medication use included Voltaren gel 1% and Zolpidem since at least 3-2015, at which time pain was rated 4 out of 10 with medication use and 9 out of 10 without. The orthopedic surgery report (7-07-2015) noted that his "knees continue to do well, relatively unchanged", at which time laxity of knees while descending stairs was reported. He also reported low back pain with numbness in his legs and right fingers with numbness and tingling. Exam noted bilateral knees without effusion, warmth or edema, and ligaments appeared stable. Follow-up in 6 months was recommended for his knees and magnetic resonance imaging of the lumbar spine was recommended. The current treatment plan included Zolpidem 10mg #30, Polyethylene glycol, Voltaren 1% topical gel 100mg tube, evaluation with orthopedic surgeon, and follow-up visit. On 9-16-2015, Utilization Review modified Ambien to 10mg #20, certified Polyethylene glycol, and non-certified evaluation with orthopedic surgeon and follow-up visit.

IMR ISSUES, DECISIONS AND RATIONALES

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

Zolpidem 10 mg Qty 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 - 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 (Chronic), Zolpidem (Ambien).

Decision rationale: The Official Disability Guidelines do not recommend the use of sleeping pills for long-term use. While sleeping pills, so-called minor tranquilizers, and anti-anxiety agents are commonly prescribed in chronic pain, pain specialists rarely, if ever, recommend them for long-term use. They can be habit-forming, and they may impair function and memory more than opioid pain relievers. There is also concern that they may increase pain and depression over the long-term. The patient has been taking Ambien for longer than the 2-6 week period recommended by the ODG. Zolpidem 10 mg Qty 30 is not medically necessary.

Voltaren 1% topical gel, 100 mg tube: Upheld

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

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

Decision rationale: According to the Official Disability Guidelines, diclofenac is not recommended as first line due to increased risk profile. A large systematic review of available evidence on NSAIDs confirms that diclofenac, a widely used NSAID, poses an equivalent risk of cardiovascular events to patients as did rofecoxib (Vioxx), which was taken off the market. According to the authors, this is a significant issue and doctors should avoid diclofenac because it increases the risk by about 40%. Voltaren 1% topical gel, 100 mg tube is not medically necessary.

Evaluation with Orthopedic surgeon: Overturned

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Surgical Considerations, and Low Back Complaints 2004, Section(s): Surgical Considerations.

Decision rationale: According to the ACOEM Guidelines, referral for surgical consultation is indicated for patients who have: "Severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies (radiculopathy), preferably with accompanying objective signs of neural compromise." Activity limitations due to radiating leg pain for more than one month or extreme progression of lower leg symptoms. Clear clinical, imaging, and electrophysiologic evidence of a lesion that has been shown to benefit in both the short and long term from surgical repair. Failure of conservative treatment to resolve disabling radicular symptoms. The patient fits the above criteria. I am reversing the previous UR decision. Evaluation with Orthopedic surgeon is medically necessary.

Follow up visit: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Follow-up Visits.

Decision rationale: The ACOEM guidelines and the Official Disability Guidelines were both reviewed in regards to follow-up visits. Each reference deals primarily with the acute aspects of an injury. There is no documentation as to why such frequent visits for follow-up would be required. The typical timeframe for follow-up visits in a chronic injury is 3-6 months. Follow up visit is not medically necessary.