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| Case Number: | CM15-0185670 | | |
| Date Assigned: | 09/25/2015 | Date of Injury: | 12/03/2007 |
| Decision Date: | 12/02/2015 | UR Denial Date: | 08/20/2015 |
| Priority: | Standard | Application Received: | 09/21/2015 |

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

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 74 year old male who sustained an industrial injury on 12-03-2007. According to a progress report dated 07-09-2015, the provider noted that chief complaints included lower back pain, cervical neck pain and bilateral shoulder pain. The injured worker had continued severe pain in the neck, low back and shoulders. Lidoderm patches helped with the shoulder pain. Pain medications helped him to continue to function and do his activities. His pain level was rated 10 on a scale of 1-10 but could decrease to 8 with the use of medications. With medications, his level of function increased and he was able to perform daily activities such as walking better, sitting, standing, housework and shopping. He had been borrowing a walker to help with his stability. He stated that the pain decreased but did not last. If he took six tablets a day, his pain decreased to 5. Exam of the lumbar spine revealed spasm. Straight leg raise was positive on the right and left at 60 degrees. Pain with lumbar range of motion was noted. Exam of the cervical spine revealed spasm. Decreased range of motion was noted. There was a healed scar anteriorly. Sensation was intact. Exam of the left shoulder revealed a positive impingement sign. Exam of the right shoulder revealed painful range of motion. There was a healed incision present and tenderness to palpation at the AC joint. MRI of the cervical spine was performed on 06-17-2015 and a MRI of the lumbar spine was performed on 06-18-2015. Diagnoses included lumbar discogenic disease severe spondylosis, multilevel chronic low back pain, status post cervical fusion from previous work related injury, cervical discogenic disease, probable cervical myelopathy, status post right shoulder surgery with residuals, left shoulder rotator cuff tear by clinical exam and history and pituitary tumor. The treatment plan included Norco, Anaprox,

Restoril, Lidoderm patches, lumbar corset and front wheeled walker. The injured worker was permanent and stationary. Documentation submitted for review dated back to 04-16-2015 and showed use of Norco at that time. A laboratory requisition form dated 05-28-2015 was submitted for review and listed Norco on an as needed basis as a current medication. An authorization request dated 08-12-2015 was submitted for review. The requested services included physical therapy evaluation for home exercise program, Norco 10-325 mg #120, Anaprox 550 mg #60, Prilosec 20 mg #60, Lidoderm patches 5% #30 and lumbar corset front wheel walker with a seat. On 08-20-2015, Utilization Review non-certified the request for Norco 10-325 mg #120, Lidoderm patches 5% #30, lumbar corset for purchase, front wheel walker with a seat and physical therapy evaluation for home exercise program and authorized the request for Anaprox 550 mg #60 and Prilosec 20 mg #60.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325mg, #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official disability Guidelines (ODG) Pain chapter Opioids for chronic pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use, Opioids for chronic pain, Opioids, long-term assessment.

Decision rationale: Review of records indicates the patient continuing to treat for chronic pain symptoms for this Permanent & Stationary 2007 injury. Reports of 4/16/15 and 7/9/16 noted pain relief from 10 to 5/10 with medications; however, current report of 7/9/15 noted VAS from 10 to 8/10 with increased use of Norco up to 6 tablets per day. Previous peer review of 7/10/15 had modified request of Norco for weaning purposes as there were no evidence of functional improvement. Although the provider has noted the pain medications had allowed the patient to continue to perform his ADLs in all reports provided in April, May, and July, there is no specific change or improvement in VAS level, functional ability while failing to make attempts at weaning off opioids as recommended. The MTUS Guidelines cite opioid use in the setting of chronic, non-malignant, or neuropathic pain is controversial. Patients on opioids should be routinely monitored for signs of impairment and use of opioids in patients with chronic pain should be reserved for those with improved functional outcomes attributable to their use, in the context of an overall approach to pain management that also includes non-opioid analgesics, adjuvant therapies, psychological support, and active treatments (e.g., exercise). Submitted documents show no evidence that the treating physician is prescribing opioids in accordance to change in pain relief, functional goals with demonstrated improvement in daily activities, decreased in medical utilization or change in functional status. There is no evidence presented of random drug testing results or utilization of pain contract to adequately monitor for narcotic safety, efficacy, and compliance. The MTUS provides requirements of the treating physician to assess and document for functional improvement with treatment intervention and maintenance of function that would otherwise deteriorate if not supported. From the submitted reports, there is no demonstrated evidence of specific functional benefit derived from the continuing use of

opioids in terms of decreased pharmacological dosing, decreased medical utilization, increased ADLs and functional work status with persistent severe pain for this chronic injury without acute flare, new injury, or progressive neurological deterioration. The Norco 10/325mg, #120 is not medically necessary or appropriate.

Lidoderm patches 5%, #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): Topical Analgesics.

Decision rationale: Chronic symptoms and clinical findings remain unchanged with medication refilled. The patient exhibits diffuse tenderness and pain on the exam to the cervical and lumbar spine and in bilateral shoulders. The chance of any type of topical improving generalized symptoms and functionality significantly with such diffuse pain is very unlikely. Topical Lidocaine is indicated for post-herpetic neuralgia, according to the manufacturer. There is no evidence in any of the medical records that this patient has a neuropathic source for the diffuse pain. Without documentation of clear localized, peripheral pain to support treatment with Lidocaine along with functional benefit from treatment already rendered for this 2007 injury without any flare-up, acute new injury, or failed first line treatment of NSAID which has been approved, medical necessity has not been established. There is no documentation of intolerance to oral medication as the patient is also on other oral analgesics. The Lidoderm patches 5%, #30 is not medically necessary or appropriate.

Lumbar corset for purchase: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back-Back Braces/Lumbar Supports.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Physical Methods.

Decision rationale: There is no indication of instability, compression fracture, or spondylolisthesis precautions to warrant a lumbar support beyond the acute injury phase. Reports have not adequately demonstrated the medical indication for the back brace. Based on the information provided and the peer-reviewed, nationally recognized guidelines, the request for an LSO cannot be medically recommended. CA MTUS states that lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. This claimant is well beyond the acute phase for this chronic P&S 2007 injury. In addition, ODG states that lumbar supports are not recommended for prevention and is under study for the treatment of nonspecific LBP and only recommended as an option for compression fractures and specific treatment of spondylolisthesis, documented instability, and post-operative treatment, not demonstrated here. The Lumbar corset for purchase is not medically necessary or appropriate.

Front wheel walker with a seat: 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) Knee Chapter, Walking aids.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee Chapter, Walking aids (canes, crutches, braces, orthoses, & walkers), page 358-359.

Decision rationale: Review of clinical exam on 7/9/16 & 5/28/15 showed unchanged findings of lumbar spasm, pain with range of motion and positive straight leg raise; otherwise without neurological deficits as the patient continues to ambulate without person assist. Report of 4/16/15 noted exam with intact sensation and 5/5 motor strength. Per Guidelines, disability, pain, and age-related impairments seem to determine the need for a walking aid; however, medical necessity for request of this walking aid has not been established as no specific limitations in ADLs have been presented. The patient is currently taking medications for the chronic pain complaints. The provider noted the patient is ambulating without documented difficulties or specific neurological deficits defined that would hinder any ADLs. Exam had no findings of correlating progressive neurological deficits in motor strength and sensation in the lower extremities nor is there any recent acute injury or surgical procedure requiring an assistive device. The patient has been participating in outpatient office visits without issues and does not appear to be home bound. Submitted reports have not demonstrated adequate support for this from a clinical perspective without new acute injury or red-flag conditions. The Front wheel walker with a seat is not medically necessary or appropriate.

Physical therapy evaluation for home exercise program: 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): Physical Medicine.

Decision rationale: Physical therapy is considered medically necessary when the services require the judgment, knowledge, and skills of a qualified physical therapist due to the complexity and sophistication of the therapy and the physical condition of the patient. However, there is no clear measurable evidence of progress with the PT treatment previously rendered including milestones of increased ROM, strength, and functional capacity. Review of submitted physician reports show no evidence of functional benefit, unchanged chronic symptom complaints, clinical findings, and functional status for this 2007 injury. There is no evidence documenting functional baseline with clear goals to be reached and the patient striving to reach those goals. The Chronic Pain Guidelines allow for visits of physical therapy with fading of treatment to an independent self-directed home program. It appears the employee has received previous therapy sessions and continues to participate in an independent home exercise program.

There is no report of acute flare-up, new injuries, or progressive change in clinical findings to support for formal PT in a patient that has been instructed on a home exercise program for this chronic P&S injury. Submitted reports have not adequately demonstrated the indication to support for this physical therapy. The Physical therapy evaluation for home exercise program is not medically necessary or appropriate.