

Case Number:	CM15-0186505		
Date Assigned:	09/28/2015	Date of Injury:	05/16/2011
Decision Date:	11/24/2015	UR Denial Date:	09/02/2015
Priority:	Standard	Application Received:	09/22/2015

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 57 year old male, who sustained an industrial injury on May 16, 2011. The injured worker was diagnosed as having cervical intervertebral disc disorder with myelopathy, rotator cuff syndrome of the shoulder, lumbar intervertebral disc disorder with myelopathy, hernia and status post arthroscopic surgery of the shoulder. Treatment to date has included diagnostic studies and medications. Evaluation on May 22, 2015, revealed left lumbar, right lumbar, right sacroiliac, left sacroiliac, sacral, right anterior shoulder, upper thoracic, right cervical dorsal and right posterior shoulder pain with associated numbness and tingling in the right anterior leg, right anterior knee, right posterior leg and right posterior knee noticeable 60% of the time. He noted dizziness secondary to stress and anxiety. He noted he felt better with medications, rest, walking and topical compounds. It was noted he had well healed surgical scars on bilateral shoulders. The range of motion was noted as decreased in the bilateral shoulders and the lumbar spine. He rated his pain at 6 on a 1-10 scale with 10 being the worst. He noted the pain was noticeable 100% of the time. Medications including Norco, Flurbiprofen and Ambien were continued. Evaluation on August 27, 2015, revealed continued pain as noted in the May 22, 2015 assessment. He rated his pain at 7 on a 1-10 scale with 10 being the worst. It was noted he was experiencing insomnia secondary to pain. It was noted he was having a flare up of lumbar and bilateral shoulder pain. Medications were continued and a lower extremity exercise kit was recommended. The RFA included a request for Norco 10/325mg #80 that was modified and requests for FCL (Flurbiprofen 20%, Baclofen 2%, Dexamethasone 2%, Menthol 2%, Camphor 2%, Capsaicin 0.0375%, Hyaluronic Acid 0.20% #180gm, DME: Lower Extremity Exercise Kit Purchase and Ambien 10mg #30 that were non-certified on the utilization review (UR) on September 2, 2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325mg #80: 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): Opioids (Classification), Opioids, California Controlled Substance Utilization Review and Evaluation System (CURES) [DWC], Opioids, criteria for use, Opioids for chronic pain.

Decision rationale: Regarding the request for Norco (hydrocodone/acetaminophen), Chronic Pain Medical Treatment Guidelines state that Norco is an opiate pain medication. Due to high abuse potential, close follow-up is recommended with documentation of analgesic effect, objective functional improvement, side effects, and discussion regarding any aberrant use. Guidelines further specify for discontinuation of opioids if there is no documentation of improved function and pain. Within the documentation available for review, there is no indication that the medication is improving the patient's function, and no documentation regarding side effects. As such, there is no clear indication for ongoing use of the medication. Opioids should not be abruptly discontinued, but unfortunately, there is no provision to modify the current request to allow tapering. In light of the above issues, the currently requested Norco (hydrocodone/acetaminophen) is not medically necessary.

Ambien 10mg #30: Upheld

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

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 Chapter & Mental Illness and Stress Chapter, Insomnia Topics.

Decision rationale: Regarding the request for Ambien, 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 subjective complaints and diagnosis of insomnia. However, there appears to be a longer-term use of Ambien in excess of guideline recommendations of 6 weeks. Given this, the currently requested Ambien is not medically necessary.

FCL (Flurbiprofen 20%, Baclofen 2%, Dexemethanoe 2%, Menthol 2%, Camphor 2%, Capsaicin 0.0375%, Hyaluronic Acid 0.20% #180gm): 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 this request, one of the components requested is topical baclofen. Chronic Pain Medical Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page 113 of 127 state the following: "Topical Baclofen: Not recommended. There is currently one Phase III study of Baclofen-Amitriptyline- Ketamine gel in cancer patients for treatment of chemotherapy-induced peripheral neuropathy. There is no peer-reviewed literature to support the use of topical baclofen." Given these guidelines, the topical baclofen is not medically necessary. Since any formulation must have all components as recommended in order for the formulation to be medically necessary, this request is not medically necessary.

DME: Lower Extremity Exercise Kit Purchase: Upheld

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

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

Decision rationale: Regarding the request for home exercise equipment, the CA MTUS state exercise is recommended but have no provisions for specialized kits or equipment. These guidelines further stipulate that there is no sufficient evidence to support the recommendation of any particular exercise regimen over any other exercise regimen. The Official Disability Guidelines (ODG), Shoulder Chapter states the following regarding Home Exercise Kits: "Recommended. See Exercises, where home exercise programs are recommended; & Physical therapy, where active self-directed home physical therapy is recommended. In this RCT a specific shoulder home exercise program resulted in 69% good outcomes versus 24% in the sham exercise group, and 20% of patients in the specific exercise group subsequently chose to undergo surgery versus 63% in the control group. (Holmgren, 2012)" Within the documentation available for review, there is no indication that the patient has failed an independent program of home exercise without equipment. Additionally, there is no statement indicating how the requested exercise equipment will improve the patient's ability to perform a home exercise program, or that the patient has been instructed in the appropriate use of such equipment to decrease the chance of further injury. In the absence of such documentation, the currently requested home exercise equipment is not medically necessary.