MAXIMUS Federal Services

Case Number:	CM15-0190728		
Date Assigned:	10/02/2015	Date of Injury:	09/28/2012
Decision Date:	12/07/2015	UR Denial Date:	09/05/2015
Priority:	Standard	Application Received:	09/28/2015

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 62 year old male, who sustained an industrial injury on 9/28/15. He reported cumulative trauma injury to the low back, bilateral wrists, and left knee. Diagnoses include head pain, cervical strain-sprain with radiculitis, thoracic strain-sprain, lumbar strain-sprain with radiculopathy, bilateral shoulder tendinitis and impingement syndrome, bilateral elbow strain-sprain, right elbow fracture, chronic overuse syndrome, right wrist cartilage tear, carpal tunnel syndrome, right knee strain-sprain, left knee meniscal tear, bilateral ankle sprain, bilateral foot sprain, insomnia, and vision loss. Treatments to date include activity modification, wrist brace, back support brace, medication therapy, physical therapy, chiropractic therapy, and cortisone injection to the right wrist. Currently, he complained of ongoing pain in the neck, back, shoulder, elbows, wrists, knees, ankles and feet and headaches, and ongoing insomnia. On 8-5-15, the physical examination documented an extensive evaluation positive for tenderness, decreased range of motion and multiple positive diagnostic tests throughout all painful areas. The Thoracic spine was tender with decreased range of motion. The plan of care included MRI of the left shoulder and knee and medication management. The documentation did not include objective data indicating medication efficacy or increased functional ability from use. The medical records did not document the current medications or when they were initiated. The appeal requested authorization for Mobic 7.5mg #30; Terocin patches #30; Ambien 5mg #30; one urine drug screen; a left shoulder MRI; and a left knee MRI. The Utilization Review dated 9-5-15, modified the request to allow Ambien 5mg #15, and denied the remaining requests.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 prescription of Mobic 7.5mg #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 (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 Mobic (meloxicam), 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, there is no indication that Naproxen is providing any specific analgesic benefits (in terms of percent pain reduction, or reduction in numeric rating scale), or any objective functional improvement. In the absence of such documentation, the currently requested Mobic (meloxicam) is not medically necessary.

1 prescription of Terocin patches #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: Regarding the request for Terocin, Terocin is a combination of methyl salicylate, menthol, lidocaine and capsaicin. Chronic Pain Medical Treatment Guidelines state that any compounded product that contains at least one drug or drug class that is not recommended is not recommended. Regarding the use of topical nonsteroidal anti-inflammatory, guidelines state that the efficacy in clinical trials for this treatment modality has been inconsistent and most studies are small and of short duration. Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the 1st 2 weeks of treatment osteoarthritis, but either not afterwards or with the diminishing effect over another two-week period. Regarding use of capsaicin, guidelines state that it is recommended only as an option for patients who did not respond to or are intolerant to other treatments. Regarding the use of topical lidocaine, guidelines the state that it is recommended for localized peripheral pain after there is evidence of a trial of first-line therapy. Within the documentation available for review, there is no indication that the patient is unable to tolerate oral NSAIDs. Oral NSAIDs have significantly more guideline support compared with topical NSAIDs. Additionally, there is no indication that the topical NSAID is going to be used for short duration. Additionally, there is no documentation of localized peripheral pain with evidence of failure of first-line therapy as recommended by guidelines prior to the initiation of topical lidocaine. Finally, there is no indication that the

patient has been intolerant to or did not respond to other treatments prior to the initiation of capsaicin therapy. In the absence of clarity regarding those issues, the currently requested Terocin is not medically necessary.

1 prescription of Ambien 5mg #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 (Chronic): Zolpidem (Ambien) (2015).

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 zolpidem (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 is no discussion regarding what behavioral treatments have been attempted to treat the patients insomnia and no statement indicating how the patient has responded to Ambien treatment. Furthermore, there is no indication that Ambien is being used for short term use as recommended by guidelines. In the absence of such documentation, the currently requested zolpidem (Ambien) is not medically necessary.

Urine Drug Screen: 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, Opioids for neuropathic pain, Opioids for osteoarthritis, Opioids, cancer pain vs. nonmalignant pain, Opioids, dealing with misuse & addiction, Opioids, differentiation: dependence & addiction, Opioids, dosing, Opioids, indicators for addiction, Opioids, long-term assessment. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter Urine Drug Testing.

Decision rationale: Regarding the request for a urine drug screen (UDS), CA MTUS Chronic Pain Medical Treatment Guidelines state the drug testing is recommended as an option. Guidelines go on to recommend monitoring for the occurrence of any potentially aberrant (or non-adherent) drug related behaviors. ODG recommends urine drug testing on a yearly basis for low risk patients, 2-3 times a year for moderate risk patients, and possibly once per month for high risk patients. Within the documentation available for review, there is no documentation that the patient is currently utilizing drugs of potential abuse. Additionally, there is no documentation

that the physician is concerned about the patient misusing or abusing any controlled substances. In light of the above issues, the currently requested urine drug screen is not medically necessary.

MRI of the Left Shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Shoulder Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Magnetic resonance imaging (MRI).

Decision rationale: Regarding the request for MRI of the left shoulder, Occupational Medicine Practice Guidelines state that more specialized imaging studies are not recommended during the 1st month to 6 weeks of activity limitation due to shoulder symptoms except when a red flag is noted on history or examination. Cases of impingement syndrome are managed the same whether or not radiographs show calcium in the rotator cuff or degenerative changes are seen in or around the glenohumeral joint or AC joint. Guidelines go on to recommend imaging studies for physiologic evidence of tissue insult or neurovascular dysfunction, failure to progress in a strengthening program intended to avoid surgery, and clarification of the anatomy prior to an invasive procedure. ODG recommends MRI of the shoulder for subacute shoulder pain with suspicion of instability/labral tear or following acute shoulder trauma with suspicion of rotator cuff tear/impingement with normal plain film radiographs. Within the documentation available for review, there is no indication that the patient has failed conservative treatment options. Furthermore, it is unclear how an MRI will change the patient's current treatment plan. In the absence of clarity regarding those issues, the currently requested left shoulder MRI is not medically necessary.

MRI of the Left Knee: Upheld

Claims Administrator guideline: Decision based on MTUS Knee Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Knee Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg, MRI.

Decision rationale: Regarding the request for MRI left knee, CA MTUS and ACOEM note that, in absence of red flags (such as fracture/dislocation, infection, or neurologic/vascular compromise), diagnostic testing is not generally helpful in the first 4-6 weeks. After 4-6 weeks, if there is the presence of locking, catching, or objective evidence of ligament injury on physical exam, MRI is recommended. ODG recommends plain radiographs in the absence of signs/symptoms of internal derangement or red flags. Within the medical information made available for review, there is no documentation that radiographs are non-diagnostic, identification of any red flags or documentation that conservative treatment aimed towards the knee has failed. In the absence of such documentation, the currently requested left knee MRI is not medically necessary.