

Case Number:	CM15-0085397		
Date Assigned:	05/07/2015	Date of Injury:	07/30/2011
Decision Date:	06/29/2015	UR Denial Date:	04/06/2015
Priority:	Standard	Application Received:	05/04/2015

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 41 year old female, who sustained an industrial injury on July 30, 2011. She reported back pain, hip joint and knee pain. The injured worker was diagnosed as having chronic knee pain status post right knee arthroscopy, meniscectomy and chondroplasty, chronic left knee pain status post arthroscopic procedure, chronic low back pain, gastric bypass history, negative electrodiagnostic studies of the lower extremities in December 2013, right greater trochanter bursitis, right hip pain and bursitis noted on magnetic resonance imaging of the hip joint. Treatment to date has included radiographic imaging, diagnostic studies, surgical interventions of bilateral knees, right trochanter injection, physical therapy, medications and work restrictions. Currently, the injured worker complains of back pain, hip joint and knee pain. The injured worker reported an industrial injury in 2011, resulting in the above noted pain. She was treated conservatively and surgically without complete resolution of the pain. She reported pain control with pain medications daily. She noted severe pain without the use of medications and disruptions in sleep and activities of daily living. With the use of pain medication, she noted attending social functions, walking in the park and performing activities of daily living. Evaluation on February 24, 2015, revealed continued pain. She noted a significant improvement lasting three months with previous trochanter injection. Evaluation on March 5, 2015, revealed continued pain as noted. Medications were requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retro: Norco (acetaminophen and hydrocodone) 325mg #210 for date of service 3/24/15:
Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 44, 47, 75-79, 120 of 127.

Decision rationale: Regarding the request for Norco (hydrocodone/acetaminophen), California Pain Medical Treatment Guidelines state that this 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 go on to recommend discontinuing opioids if there is no documentation of improved function and pain. Within the documentation available for review, there is indication that the medication is improving the patient's function and pain with no intolerable side effects or aberrant use. In light of the above, the currently requested Norco (hydrocodone/acetaminophen) is medically necessary.

Retro: Ambien (Zolpidem) 5mg #30 for date of service 3/24/15: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

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 and 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.

Retro: Flexeril (Cyclobenzaprine) 7.5mg #15 for date of service 3/24/15: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines muscle relaxants.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 63-66 of 127.

Decision rationale: Regarding the request for cyclobenzaprine (Flexeril), Chronic Pain Medical Treatment Guidelines support the use of non-sedating muscle relaxants to be used with caution as a 2nd line option for the short-term treatment of acute exacerbations of pain. Guidelines go on to state that cyclobenzaprine specifically is recommended for a short course of therapy. Within the documentation available for review, it does not appear that this medication is being prescribed for the short-term treatment of an acute exacerbation, as recommended by guidelines. In the absence of such documentation, the currently requested cyclobenzaprine (Flexeril) is not medically necessary.

Retro: Celebrex (Celecoxib) 200mg #30 for date of service 3/24/15: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines non-steroidal anti-inflammatory drugs (NSAIDs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 22 and 30 of 127.

Decision rationale: Regarding the request for celecoxib (Celebrex), Chronic Pain Medical Treatment Guidelines state that Celebrex may be considered if the patient has a risk of GI complications. Within the documentation available for review, the patient has a history of gastric bypass and cannot utilize non-specific NSAIDs. There is documentation of significant pain relief and functional benefit from medications without intolerable side effects. In light of the above, the currently requested celecoxib (Celebrex) is medically necessary.