MAXIMUS Federal Services

Case Number:	CM14-0119239		
Date Assigned:	08/06/2014	Date of Injury:	03/09/2012
Decision Date:	10/08/2014	UR Denial Date:	07/01/2014
Priority:	Standard	Application Received:	07/28/2014

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. The expert reviewer is Board Certified in Physical Medicine & Rehabilitation, and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 66-year-old male who reported an injury on 03/09/2012 due to an unknown mechanism of injury. The injured worker reportedly sustained an injury to his low back and shoulder. The injured worker's treatment history included physical therapy, medication, chiropractic care, and acupuncture. The injured worker was evaluated on 06/19/2014. It was documented that injured worker had continued low back pain complaints and left shoulder complaints. Physical findings included tenderness to palpation of the anterior shoulder with restricted range of motion and a positive impingement sign. Evaluation of the lumbar spine documented tenderness to the paravertebral musculature with noted spasming and restricted range of motion. The injured worker had a left sided positive straight leg raising test and reduced sensation in the left foot. The injured worker's diagnoses included lumbar radiculopathy and shoulder impingement. The injured worker's medications were noted to be hydrocodone/APAP, ketoprofen, omeprazole, orphenadrine, Medrox pain relief ointment, and zolpidem 10 mg. The injured worker's treatment plan included a back brace, physical therapy, and continuation of medications. No Request for Authorization form was submitted to support the request.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hydrocodone/Apap 10/325mg Qty 60 w/2 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ioids, On-Going Management Page(s): 78.

Decision rationale: The California Medical Treatment Utilization Schedule recommends the ongoing use of opioids in the management of chronic pain be supported by documentation of functional benefit, a quantitative assessment of pain relief, managed side effects, and evidence that the injured worker is monitored for aberrant behavior. The clinical documentation submitted for review does not provide any evidence that the injured worker is monitored for aberrant behavior. Additionally, there was no documentation of functional benefit or decreased pain levels resulting from medication usage. The clinical documentation submitted for review does indicate that the injured worker has been on this medication since at least 01/2014. Without documentation to support efficacy, continued use would not be supported. Furthermore, the request as it is submitted does not clearly identify a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested treatment is not medically necessary or appropriate.

Orphenadrine ER 100mg Qty 60 w/ 2 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63.

Decision rationale: The California Medical Treatment Utilization Schedule does not support the use of muscle relaxants in the management of chronic pain. Guidelines recommend that muscle relaxants be restricted to 2 to 3 weeks of treatment to treat acute exacerbations of chronic pain. The clinical documentation submitted for review does indicate that the injured worker has been taking this medication since at least 05/2014. This in combination with the requested medication exceeds Guideline recommendations. There are no exceptional factors noted within the documentation to support extending treatment beyond Guideline recommendations. Therefore, continued use of this medication would not be supported. Additionally, the request as it is submitted does not provide a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the request is not medically necessary or appropriate.

Medrox pain relief ointment w/2 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

Decision rationale: The requested medication is a compounded medication that contains menthol, methyl salicylate, lidocaine, and capsaicin. The California Medical Treatment Utilization Schedule does recommend the use of menthol and methyl salicylate in the management of osteoarthritic pain. The California Medical Treatment Utilization Schedule does not support the use of lidocaine in a cream or gel formulation as there is little scientific evidence to support the efficacy and safety of this medication. Furthermore, the California Medical Treatment Utilization Schedule does not support the use of capsaicin unless all other chronic pain treatments have failed to provide pain relief to the patient. The clinical documentation submitted for review does not provide any evidence that the injured worker has failed to respond to first line medications to include anticonvulsants or antidepressants. Therefore, topical use of capsaicin would not be supported. Furthermore, the request as it is submitted does not provide a frequency of treatment or applicable body part. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the request is not medically necessary or appropriate.

Zolpidem Tartrate tab 10mg: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITIES GUIDELINES

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

Decision rationale: The California Medical Treatment Utilization Schedule does not address this medication. The Official Disability Guidelines recommend the use of zolpidem in the management of insomnia related complaints for short durations of treatment after the injured worker has failed to respond to nonpharmacological interventions. The clinical documentation submitted for review does indicate that the injured worker has been on this medication since at least 05/2014. Additionally, there is no documentation of efficacy of treatment of this medication. There is not an adequate assessment of the patient's current sleep hygiene resulting from the use of this medication. Additionally, the clinical documentation does not provide any evidence that the injured worker has failed to respond to nonpharmacological treatments of insomnia complaints. Furthermore, the request as it is submitted does not clearly identify a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the request is not medically necessary or appropriate.