MAXIMUS Federal Services

Case Number:	CM14-0143371		
Date Assigned:	09/29/2014	Date of Injury:	02/17/2003
Decision Date:	11/10/2014	UR Denial Date:	08/14/2014
Priority:	Standard	Application Received:	09/04/2014

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 Texas and Ohio. 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 71-year-old female who reported an injury on 02/17/2003. The mechanism of injury involved a fall. The current diagnoses include lumbar radiculopathy, cervical radiculopathy, left shoulder impingement/rotator cuff tear, secondary depression/anxiety, probable secondary hypertension, status post falls, abnormal lab testing, right shoulder pain/strain, and secondary high blood pressure due to chronic pain. The injured worker was evaluated on 07/16/2014. Previous conservative treatment is noted to include medications, physical therapy, and epidural steroid injections. The current medication regimen includes Norco, Opana IR, Soma, Ambien, Lisinopril, Linzess, Prozac, and Valium. The injured worker presented with complaints of intense lower back pain, left shoulder pain, headaches, depression, anxiety, left foot and ankle pain, right shoulder pain, recurrent falls, and constipation. Physical examination revealed moderate to severe tenderness of the lumbosacral region, limited lumbar range of motion, positive straight leg raising on the right, slight to moderate tenderness of the acromioclavicular region of the left shoulder, positive impingement sign bilaterally, limited range of motion of the bilateral shoulders, slight paracervical muscle spam on the right, limited cervical range of motion, positive Spurling's maneuver on the right, and a moderately antalgic gait. The injured worker's mood and affect were noted to be moderately depressed. Treatment recommendations at that time included continuation of the current medication. There was no Request for Authorization form submitted for this review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325mg, #180, 2 tablets 3 times a day (tid) for pain control: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 79-81. Decision based on Non-MTUS Citation Opioid Therapy for Chronic Pain. N Engl J Med 2003; 349; 1943-1953 November 13, 2003 DOI: 10.1056/NEJMra025411 Http://www.americanpainsociety.org/uploads/pdfs/Opioid_Final_Evidence_Report.pdf

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

Decision rationale: California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. The injured worker has continuously utilized this medication since 01/2014. There is no documentation of objective functional improvement. There is no evidence of a significant change in the injured worker's physical examination that would indicate functional improvement. The injured worker continued to present with complaints of intense lower back pain, as well as bilateral upper extremity pain, and left lower extremity pain. Based on the clinical information received, the request is not medically necessary.

Opana IR 10mg, #45, 1 tablet 3 times a day as needed for pain control: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 79-81. Decision based on Non-MTUS Citation Opioid Therapy for Chronic Pain. N Engl J Med 2003; 349; 1943-1953 November 13, 2003 DOI: 10.1056/NEJMra025411 Http://www.americanpainsociety.org/uploads/pdfs/Opioid_Final_Evidence_Report.pdf

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

Decision rationale: California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. The injured worker has continuously utilized this medication since 01/2014. There is no documentation of objective functional improvement. There is no evidence of a significant change in the injured worker's physical examination that would indicate functional improvement. The injured worker continued to present with complaints of intense lower back pain, as well as bilateral upper extremity pain, and left lower extremity pain. Based on the clinical information received, the request is not medically necessary.

Soma 350mg, #90, three times a day as needed for muscle spasm control: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63-66.

Decision rationale: California MTUS Guidelines state muscle relaxants are recommended as non-sedating second line options for short term treatment of acute exacerbations. The injured worker has continuously utilized this medication since 01/2014. Despite the ongoing use of this medication, the injured worker continues to demonstrate paracervical muscle spasm. There is no documentation of objective functional improvement. Therefore, the request is not medically necessary.

Ambien 10mg, #60, 2 tablets at bedtime as needed for sleep due to chronic pain: 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, Insomnia treatment

Decision rationale: The Official Disability Guidelines state insomnia treatment is recommended based on etiology. Ambien is indicated for the short term treatment of insomnia with difficulty of sleep onset for 7 to 10 days. The injured worker has utilized this medication since 01/2014. However, the injured worker does not maintain a diagnosis of insomnia or sleep disorder. There is no documentation of a failure to respond to non-pharmacologic treatment. Based on the clinical information received, the request is not medically necessary.

Thermacare heat patches, #60, 1 twice a day as needed: 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), Low back chapter and www.drugs.com/drp/thermacare-heat-wraps.html)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-300.

Decision rationale: California MTUS/ACOEM Practice Guidelines at home local applications of heat or cold are as effective as those performed by a therapist. There is no mention of a contraindication to at home local applications of heat as opposed to Thermacare heat patches. The injured worker has also utilized Thermacare heat patches since 01/2014 without any evidence of objective functional improvement. As such, the request is not medically necessary.

Voltaren Gel 1% 2-4gm four times a day, applied locally to affected areas: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 112.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: California MTUS Guidelines state the only FDA approved topical NSAID is Voltaren gel 1%, which is indicated for the relief of osteoarthritis pain in joints that lend themselves to topical treatment. It has not been evaluated for treatment of the spine, hip, or shoulder. As such, the current request cannot be determined as medically appropriate in this case.

Linzess 145 mcg tablets, 1 at bed time(qhs) for constipation: 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 www.nlm.nih.gov. U.S. National Library of Medicine. U.S. Department of Health and Human Services National Institutes of Health. Updated: 24 Sept 2014

Decision rationale: According to the US National Library of Medicine, Linzess is used in adults to treat irritable bowel syndrome with constipation and chronic idiopathic constipation. The injured worker has continuously utilized this medication since 01/2014. Despite the ongoing use of this medication, the injured worker continues to report constipation related to opioid medication. The injured worker does not maintain a diagnosis of irritable bowel syndrome or idiopathic constipation. Based on the clinical information received, the request is not medically necessary.

Valium 5mg, #90, 1 tablet three times a day for anxiety due to pain: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

Decision rationale: California MTUS Guidelines state benzodiazepines are not recommended for long term use because long term efficacy is unproven and there is a risk of dependence. The injured worker has continuously utilized this medication since 01/2014. There is no documentation of objective functional improvement. California MTUS Guidelines do not recommend long term use of benzodiazepines. Therefore, the request is not medically necessary.