

Case Number:	CM14-0218129		
Date Assigned:	01/07/2015	Date of Injury:	10/21/2011
Decision Date:	03/06/2015	UR Denial Date:	12/12/2014
Priority:	Standard	Application Received:	12/30/2014

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. 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: Internal Medicine

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 61-year-old male, with a reported date of injury of 10/21/2011. The results of the injury were neck pain, low back pain, right shoulder pain, left knee pain, and right hip pain. The current diagnoses were right shoulder thickness tear of the supraspinatus, status post L3-S1 laminectomy and decompression with residual mild right leg pain, and sleep issues. The past diagnoses were right shoulder rotator cuff syndrome, status post right shoulder rotator cuff repair, chronic lumbar strain with disc herniation, failed back syndrome, right knee meniscal syndrome, and status post right knee arthroscopy. Treatments have included Norco, physical therapy, x-ray of the lumbar spine on 08/07/2014, L3-4, L4-5, and L5-S1 laminectomy and decompression, exploration of fusion, and hardware removal, and an MR arthrography of the right shoulder on 07/16/2014, which showed a tear of the inferior acromioclavicular ligament, and a high-grade partial thickness re-tear of the articular fibers of the distal supraspinous tendon. The medical records provided for review include ten (10) physical therapy reports from 09/29/2014 to 11/04/2014. The progress report (PR-2) dated 11/20/2014 indicates that the injured worker had persistent pain in the neck and low back. He rated the pain a 5 out of 10. He also complained of pain in the right shoulder that was worsening with numbness. He rated the right shoulder pain a 5 out of 10. The injured worker had pain in the left knee and right hip, which was rated a 6 out of 10 and constant. An examination of the cervical spine revealed decreased range of motion. An examination of the right shoulder revealed forward flexion at 140 degrees, internal rotation and external rotation at 60 degrees; tenderness of the subacromial space; decreased strength in flexion, abduction, and external rotation. An examination of the lumbar

spine showed tenderness over the midline with limited flexion and extension because of pain, and normal neurological status of the bilateral lower extremities. It was noted that the physical therapy was not helping the right shoulder, since the injured worker had an 80% thickness tear. The request for Norco was for refill, the Restoril was requested for sleep, and the MRI of the lumbar spine was recommended by another treating physician. On 11/12/2014, Utilization Review (UR) denied the request for Restoril 15mg #30, and an MRI of the lumbar spine. The UR modified the request for Norco 10/325mg #120. The UR physician noted that there was no current urinalysis and opiate contract; Restoril is not recommended for long-term use; and there were no clinical findings that require an MRI of the lumbar spine and the injured worker already had multiple surgeries on the spine. The Chronic Pain Guidelines and Official Disability Guidelines were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco (Hydrocodone) 10/325mg #120: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines On-going monitoring.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page 74-96. Hydrocodone/Acetaminophen Page 91..

Decision rationale: Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines (page 89) present the strategy for maintenance for long-term users of opioids. "Do not attempt to lower the dose if it is working." Supplemental doses of break-through medication may be required for incidental pain, end-of dose pain, and pain that occurs with predictable situations. The standard increase in dose is 25 to 50% for mild pain and 50 to 100% for severe pain. Actual maximum safe dose will be patient-specific and dependent on current and previous opioid exposure, as well as on whether the patient is using such medications chronically. Hydrocodone/Acetaminophen (Norco) is indicated for moderate to moderately severe pain. The primary treating physician's progress report dated November 20, 2014 documented that shoulder rotator cuff repair surgery was recommended. The patient is status post L3 through S1 laminectomy and decompression and hardware removal performed on August 7, 2014. Medical records document objective evidence of pathology. Medical records document objective physical examination findings. No adverse side effects were reported. Analgesia was documented. Evaluation for aberrant behavior was documented. Activities were addressed. No adverse side effects were reported. Medical records document regular physician clinical evaluations and monitoring. Per MTUS, Hydrocodone/Acetaminophen (Norco) is indicated for moderate to moderately severe pain. The request Norco (Hydrocodone/Acetaminophen) is supported by the medical records and MTUS guidelines. Therefore, the request for Norco 10/325 mg #120 is medically necessary.

Restoril (Temazepam) 15mg #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Pain Insomnia, Pharmacologic treatment

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

Decision rationale: Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines (Page 24) states that benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. ODG guidelines state that benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there is a risk of psychological and physical dependence or frank addiction. ODG guidelines states that Restoril (Temazepam) is not recommended. The primary treating physician's progress report dated November 20, 2014 documented a request for Restoril (Temazepam) 15 mg every night. There were no subjective complaints of insomnia. The long-term use of benzodiazepines is not supported by MTUS guidelines. ODG guidelines indicates that Restoril (Temazepam) is not recommended. Therefore, the request for Restoril (Temazepam) 15 mg #30 is not medically necessary.

MRI Lumbar Spine w/o dye: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 289-291, 303-305, 308-310.

Decision rationale: Medical Treatment Utilization Schedule (MTUS) addresses magnetic resonance imaging MRI of the lumbosacral spine. American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) Chapter 12 Low Back Complaints states neurologic deficit is a red flag for potentially serious low back conditions. Red flags include severe low back pain, progressive numbness or weakness, significant progression of weakness, significant increased sensory loss, new motor weakness, and radicular signs. MRI magnetic resonance imaging is indicated to define a potential cause of tissue insult or nerve impairment. MRI is the test of choice for patients with prior back surgery. The orthopedic spine surgeon's report dated November 7, 2014 documented a request for a new MRI magnetic resonance imaging of the lumbar spine to rule out a new residual nerve compression versus hematoma. The patient may need an injection versus possible surgical intervention and repeat decompression. The patient is three months status post L3 through S1 laminectomy and decompression and hardware removal performed on August 7, 2014. The patient reported persistent right lower extremity pain. Physical examination demonstrated right lower extremity motor weakness. Because medical records document neurologic deficits and a history of lumbosacral spine surgery and consideration for surgical intervention, the request for MRI of the lumbar spine is supported by ACOEM and MTUS guidelines. Therefore, the request for MRI lumbar spine is medically necessary.