

Case Number:	CM15-0117503		
Date Assigned:	06/25/2015	Date of Injury:	07/11/2006
Decision Date:	12/08/2015	UR Denial Date:	05/21/2015
Priority:	Standard	Application Received:	06/18/2015

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: Texas, Florida

Certification(s)/Specialty: Anesthesiology, 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 51 year old female who sustained an industrial injury on July 11, 2006. An initial pain evaluation visit dated May 11, 2015 reported subjective complaint of shoulder pain, constant neck pain radiating down bilateral upper extremity associated with bilateral occipital and bilateral frontal headaches. She also has complaint of bilateral shoulders with pain right side greater that radiates to the thoracic spine. In addition she has complaint of insomnia secondary to ongoing pain. She also complains of gastric upset from medications use. Previous treatments to include: activity modification, medications, chiropractic care and acupuncture. The following diagnoses were applied to this visit: cervical radiculitis; bilateral shoulder pain; gastroesophageal disorder, and medications related dyspepsia. There is mention of the primary treating requesting that pain management take over prescribing with note of: stable dose many years Norco and Soma, as well as Naproxen, Prilosec and Polar Frost. The plan of care noted renewing the following current medications: Carisoprodol, Naproxen, Norco, Vicodin, Omeprazole, and Polar Frost. The 2/5/2015 UDS was inconsistent with the absence of prescribed medications. A primary treating office visit dated February 25, 2014 reported current medication regimen consisting of: polar Freeze, Norco, Soma, Prilosec, and Anaprox. Subjective complaint noted that there was no change in her symptoms. She was reported to be tolerating the medications well. She was switched from Vicodin ES to Norco 7.5 mg and reported that the Norco was not strong enough. The Norco was increased to 10mg twice daily as needed. On May 15, 2015 a request was made for Norco 10mg / 325mg #60, and Polar Frost 4% gel #1 both which were non certified by Utilization Review on May 21, 2105.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325mg #60: 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): Medications for chronic pain, Opioids, criteria for use, Opioids for chronic pain, Opioids, dealing with misuse & addiction, Opioids, differentiation: dependence & addiction, Opioids, long-term assessment, Opioids, screening for risk of addiction (tests), Opioids, steps to avoid misuse/addiction, Opioid hyperalgesia, Weaning of Medications.

Decision rationale: The CA MTUS and the ODG guidelines recommend that opioids can be utilized for the treatment of severe musculoskeletal pain when standard NSAIDs, exercise and PT have failed. The chronic use of NSAIDs can be associated with the development of tolerance, dependency, addiction, sedation and adverse interaction with sedative medications. The records indicate inconsistent compliance monitoring report and lack of functional restoration with chronic utilization of opioids. The utilization of increasing doses of opioids without objective findings of functional restoration can be indicative of tolerance and opioid induced hyperalgesia. The criteria for the use of Norco 10/325mg #60 was not met. The request is not medically necessary.

Polar Frost 4% gel #1: 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): Medications for chronic pain, Nonprescription medications, Topical Analgesics. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter Topical Analgesics Cold Therapy.

Decision rationale: The CA MTUS and the ODG guidelines recommend that topical cold therapy can be utilized for the treatment of acute musculoskeletal pain. The utilization of Cold Therapy can be associated with reduction in pain, decreased swelling and improvement in range of motions. The guidelines did not support the utilization of OTC topical applications or Cold Therapy beyond the acute pain phase. The records did not show any recent re-injury or musculoskeletal surgery. The criteria for the use of Polar Frost 4% gel #1 was not met. The request is not medically necessary.

MRI of the cervical spine without contrast: Upheld

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines -Neck and Upper Back (Acute & Chronic).

MAXIMUS guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Special Studies, Diagnostic Criteria. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter Neck and Upper Back MRI.

Decision rationale: The CA MTUS and the ODG guidelines recommend that MRI can be utilized for the evaluation of cervical spine condition when physical examinations and X-ray evaluation of neurological deficits is inconclusive. The records did not show subjective or objective findings consistent with worsening cervical spine condition or neurological deficit. The criteria for MRI of the cervical spine without contrast was not met. The request is not medically necessary.

Prilosec 20mg #30: Overturned

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, GI symptoms & cardiovascular risk, NSAIDs, specific drug list & adverse effects.

Decision rationale: The CA MTUS and the ODG guidelines recommend that NSAIDs can be utilized for the prevention and treatment of gastrointestinal disease. The chronic use of NSAIDs can be associated with the development of cardiovascular, renal and gastrointestinal disease. The records indicate that the patient had significant NSAIDs associated gastrointestinal symptoms that is relieved with the use of Prilosec. The criteria for the use of Prilosec 20mg #60 was met. The request is medically necessary.