

Case Number:	CM15-0126401		
Date Assigned:	07/10/2015	Date of Injury:	07/28/2005
Decision Date:	08/18/2015	UR Denial Date:	06/18/2015
Priority:	Standard	Application Received:	06/30/2015

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: Emergency 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 was a 66-year-old female, who sustained an industrial injury, July 28, 2005. The injury was sustained when the injured worker was transferring her daughter from the wheelchair to the shower-chair and fell. The injured worker tried to keep her daughter from falling, but injured the right wrist and wrenched the back. The injured worker previously received the following treatments EMG/NCS (electrodiagnostic studies and nerve conduction studies) of the bilateral upper extremities was negative on January 30, 2006, right wrist surgery in 2006, 3-4 epidural injections, Norco, thoracic spine MRI, lumbar flexion/extension lateral x-rays, Percocet, OxyContin, Celexa, lotions and right wrist brace. The injured worker was diagnosed with right wrist surgery times 2, lumbar discogenic disease, lumbar facet syndrome, lumbar radiculitis, chronic lumbar back pain with lumbar degenerative disc disease, CRPS (complex regional pain syndrome) of the right wrist, right rotator cuff syndrome and right ulnar neuritis. No recent documentation was provided. Only documentation provided is a QME from 7/2014. No additional information or progress notes were provided for review. According to QME progress note of July 3, 2014, the injured worker's chief complaint was right wrist pain and back pain. The injured worker rated the pain at 8 out of 10, right wrist pain. The physical exam noted the injured worker was in moderate distress, unable to find a comfortable position unless lying down. The treatment plan included prescription refills for Hydrocodone/APAP, Cyclobenzaprine, Ranitidine and Lidocaine Patches.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hydrocodone/APAP 10/325mg, 150: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Long-term use of opiates.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 76-79.

Decision rationale: Norco is acetaminophen and hydrocodone, an opioid. Patient has chronically been on an opioid pain medication. As per MTUS Chronic pain guidelines, documentation requires appropriate documentation of analgesia, activity of daily living, adverse events and aberrant behavior. Documentation fails criteria. There is no recent progress notes provided. It is unclear why patient is on this medication, how long patient has been on this medication or what response has been achieved with this medication. The lack of any recent progress notes does not meet MTUS criteria regarding need for documentation. Medication cannot be approved with any recent medical information. Norco is not medically necessary.

Cyclobenzaprine 10mg, #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 97.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril) Page(s): 41-42.

Decision rationale: Flexeril is cyclobenzaprine, a muscle relaxant. As per MTUS guidelines, evidence shows that it is better than placebo but is considered a second line treatment due to high risk of adverse events. It is recommended only for short course of treatment for acute exacerbations. There is some evidence of benefit in patients with fibromyalgia. There is no recent progress notes provided. It is unclear why patient is on this medication, how long patient has been on this medication or what response has been achieved with this medication. The lack of any recent progress notes does not meet MTUS criteria regarding need for documentation. Medication cannot be approved with any recent medical information. Cyclobenzaprine is not medically necessary.

Ranitidine 150mg, #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines PPI (Proton Pump Inhibitor) Page(s): 102.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms and cardiovascular risk Page(s): 68-69.

Decision rationale: Ranitidine is an H2 blocker, which is used to treat gastritis/peptic ulcer disease, acid reflux or dyspepsia from NSAIDs. As per MTUS guidelines, medications may be recommended in patients with dyspepsia or high risk for GI bleeding on NSAID. There is no dyspepsia complaints documented. Patient is not high risk for GI bleeding. There is no recent progress notes provided. It is unclear why patient is on this medication, how long patient has been on this medication or what response has been achieved with this medication. The lack of any recent progress notes does not meet MTUS criteria regarding need for documentation. Medication cannot be approved with any recent medical information. Ranitidine is not medically necessary.

Lidocaine pad 5%, #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Lidocaine Page(s): 90.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm (lidocaine patch) Page(s): 56-57.

Decision rationale: As per MTUS chronic pain guidelines, lidoderm is only approved for peripheral neuropathic pain, specifically post-herpetic neuralgia. There is poor evidence to support its use in other neuropathic pain conditions such as spinal pain. There is no recent progress notes provided. It is unclear why patient is on this medication, how long patient has been on this medication or what response has been achieved with this medication. The lack of any recent progress notes does not meet MTUS criteria regarding need for documentation. Medication cannot be approved with any recent medical information. Lidocaine patch is not medically necessary.