MAXIMUS Federal Services

Case Number:	CM15-0169029		
Date Assigned:	09/09/2015	Date of Injury:	10/25/2006
Decision Date:	11/13/2015	UR Denial Date:	08/03/2015
Priority:	Standard	Application Received:	08/27/2015

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: New York
Certification(s)/Specialty: Pediatrics, 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 54-year-old male, who sustained an industrial injury on 10-25-06. The injured worker has complaints of intermittent moderate neck pain with recurring headaches and frequent pain in both knees aggravated by prolonged walking and standing and cold weather. The injured worker has complaints of frequent pain in his mid and low back aggravated with bending, twisting, lifting, carrying, pushing and pulling associated with intermittent weakness, numbness and tingling. The injured worker has frequent pain in his left ankle aggravated with prolonged standing and walking and cold weather. The documentation noted on 7-14-15 the injured worker relates the left wrist pain has resolved since he had surgery. The injured worker has complaints of acid reflux, blood in his stool and constipation due to pain medications he is taking. Cervical spine examination revealed there is increased tone with associated tenderness about the paracervical and trapezial muscles and some guarding on examination. The lumbosacral examination revealed there is increased tone and tenderness about the paralumbar musculature with tenderness at the midline thoraco-lumbar junction and over the level of L5-S1 (sacroiliac) facets and right greater sciatic notch and there are muscle spasms. The injured workers lower extremity examination reveals tenderness to the lateral and medial joint line bilaterally. Left foot and ankle has diffuse tenderness noted. The diagnoses have included cervical spine sprain and strain; lumbar spine sprain and strain; status post bilateral knee arthroscopy with residuals; left foot strain status post-surgery and chronic gastritis secondary to non-steroidal anti-inflammatory drugs (NSAIDs) gastropathy. Treatment to date has included bilateral knee surgeries two times for each knee, dates unrecalled; left wrist fracture repair surgery in November 2006; left ankle surgery in 2013; Norco; Ambien; Tramadol; Omeprazole; Cyclobenzaprine for muscle spasms; Nabumetone for pain and inflammation and Ibuprofen. The documentation noted that the injured

worker was hospitalized in 2009 for treatment of shock that was induced by mixture of pain medications. The original utilization review (8-3-15) had an original request for Ambien 10mg #30; Ultracet 37.5mg #60; Maalox one bottle; Nabumetone 750mg #60; Omeprazole 20mg #60; Cyclobenzaprine 10mg #60 and chiropractic therapy two times a week for four weeks (not specified for which body parts). The request for request for Ultracet 37.5mg #60 was modified to 37.5mg #45 and the request for Maalox one bottle and for Omeprazole 20mg #60 was approved. The request for Ambien 10mg #30, Nabumetone 750mg #60, Cyclobenzaprine 10mg #60 and for chiropractic therapy two times a week for four weeks (not specified for which body parts) were all non-approved.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ambien 10mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Sleep aid.

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

Decision rationale: Per ODG pharmacological agents for insomnia should only be used after careful evaluation of potential causes of sleep disturbance for the etiology. Ambien is indicated for the short-term treatment of insomnia with difficulty of sleep onset (7-10 days). Ambien CR is indicated for treatment of insomnia with difficulty of sleep onset and/or sleep maintenance. There is no discussion of an investigation into the origin of the sleep disturbance and non-pharmacological interventions that may have been utilized. This request is not medically necessary and appropriate.

Ultracet 37.5 mg #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): Opioids, criteria for use, Opioids for chronic pain.

Decision rationale: The IW has been on long-term opioids which is not recommended. Additionally, documentation did not include review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. This request is not medically necessary and reasonable.

Nabumetone 750mg #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): NSAIDs (non-steroidal anti-inflammatory drugs), NSAIDs, specific drug list & adverse effects.

Decision rationale: According to the MTUS and ODG guidelines NSAID's are recommended as a second-line treatment after acetaminophen for exacerbations of chronic back pain. NSAID's are recommended for osteoarthritis, chronic back pain and acute exacerbations of back pain. There is no documentation how long the IW had been on Nabumetone nor the response to the medication. There is no evidence that the IW had an adequate trial of acetaminophen before initiation of NSAID's. This request is not medically necessary and appropriate.

Cyclobenzaprine 10mg #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): Muscle relaxants (for pain).

Decision rationale: Per MTUS guidelines, muscle relaxants are recommended for a short course of therapy. Limited, mixed-evidence does not allow for a recommendation for chronic use. The greatest effect appears to be in the first 4 days of treatment. The documentation does reference muscle tension that the Flexeril would be used for however at this time frame it is not indicated. This request is not medically necessary and appropriate.

Chiropractic therapy 2 times a week for 4 weeks (not specified for which body part(s): 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): Manual therapy & manipulation.

Decision rationale: Per MTUS guidelines manual therapy is recommended for chronic pain if caused by musculoskeletal conditions. Manual Therapy is widely used in the treatment of musculoskeletal pain. There are specific guidelines for frequency and duration of therapy depending on the location being treated. Without a specific location noted for treatment the request cannot be approved as there are areas that are not indicated to be treated with chiropractic care. The request is not medically necessary and appropriate.