

Case Number:	CM15-0176564		
Date Assigned:	09/23/2015	Date of Injury:	01/30/2003
Decision Date:	11/20/2015	UR Denial Date:	08/07/2015
Priority:	Standard	Application Received:	09/08/2015

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, 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 is a 63 year old female who sustained an industrial injury on 1-30-03. A review of the medical records indicates she is undergoing treatment for overuse syndrome of both upper extremities with bilateral wrist, hand, and forearm tendinitis, right greater than left - mostly right trigger thumb and DIP joint (currently stable), as well as bilateral carpal tunnel syndrome, right greater than left. She is also being treated for bilateral shoulder and trapezius strain, right worse than left, and secondary cervical strain due to overuse, right worse than left. Medical records (5-11-15 to 7-16-15) indicate ongoing complaints of bilateral wrist, hand and forearm pain, neck, shoulder, and trapezius pain, more on the right side, and sleep difficulty due to chronic pain from the above diagnoses. The physical examination (7-16-15) reveals "slight" tenderness over the distal forearm and volar wrist bilaterally, affecting the right side greater than the left side. Phalen's sign is positive bilaterally "at 30 seconds producing paresthesias of the second through fifth digit," more prominent on the right side. Finkelstein's test is noted to be "mildly positive" on the right side. Range of motion is within normal limits. Examination of the cervical spine reveals "slight" tenderness and spasm, mostly in the right paracervical region extending into the right trapezius and right scapular region. Range of motion is noted to be limited. "Slight" tenderness of the trapezius and right shoulder over the acromioclavicular region is noted "to a slight degree" and the left side is noted to be "mildly tender". Right shoulder flexion and abduction are noted to be "170 degrees". The left shoulder range of motion is "normal". Diagnostic studies are not included in the provided records. Treatment has included at least 12 sessions of physical therapy, a TENS unit, a home exercise program, and

medications. Her medications include Norco 5-325 as needed for "flare-ups" of "intense pain", Flexeril 5mg at bedtime for muscle spasms - the record indicates she "takes this intermittently", Naproxen 550mg twice daily as needed for pain and inflammation, Ambien 10mg at bedtime as needed for sleep difficulty due to chronic pain, and Ranitidine. She was noted to be taking all medications on the 5-11-15 progress report. The utilization review (8-7-15) indicates requested treatments as Norco 5-325, #15, Flexeril 5mg at bedtime, #30, Naproxen sodium 550mg twice daily as needed for pain, Ambien 10mg at bedtime as needed, #15, Ranitidine 150mg, 1-2 tablets every day, and TENS unit supplies. The UR indicates modification of the TENS units supplies to three months, in order to re-evaluate efficacy of the treatment at that time. In regards to all requested medications, denial was determined based on the following rationale: 1. Norco: "documentation does not identify measureable analgesic benefit with the use of opioids and there is no documentation of functional or vocational benefit with ongoing use". 2. Flexeril: "there is no significant functional benefit noted with the use of muscle relaxants" and "there is no indication this patient is currently experiencing an acute flare-up of symptoms, and date of injury is noted to be in 2003, ongoing use of this medication is not supported by the guideline criteria." 3. Naproxen sodium: "the patient has chronic pain from an injury sustained in 2003. Long-term use of NSAIDs is not recommended. The medical records do not clearly establish when this medication was started or duration of treatment". 4. Ambien: "given duration of use appears to exceed the recommended 2-6 week use, ongoing utilization of this medication is not indicated or supported as medical necessary." 5. Ranitidine: "the medical records do not describe the patient having gastrointestinal issues or GERD and the patient is not at risk for GI bleed or ulcer."

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 5/325mg #15: 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 (Classification), Opioids, criteria for use.

Decision rationale: CA MTUS, chronic pain guidelines, offer very specific guidelines for the ongoing use of narcotic pain medication to treat chronic pain. These recommendations state that the lowest possible dose be used as well as "ongoing review and documentation of pain relief, functional status, appropriate medication use and its side effects." It also recommends that providers of opiate medication document the injured worker's response to pain medication including the duration of symptomatic relief, functional improvements, and the level of pain relief with the medications. The included documentation fails to include the above recommended documentation. The requesting provider documents the IW has decreased use of Norco, but does not document the actual frequency of use or the IW's response to pain with this medication. In addition, the request does not include dosing frequency or duration. There is no toxicology report included in the record. The request for Norco analgesia is not medically necessary.

Flexeril 5mg at bedtime #30: 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): Cyclobenzaprine (Flexeril).

Decision rationale: According to CA MTUS, cyclobenzaprine is recommended as an option for short course of therapy. Effect is noted to be modest and is greatest in the first 4 days of treatment. The IW has been receiving this prescription for a minimum of 6 months according to submitted records. This greatly exceeds the recommended timeframe of treatment. The requesting provider documents the IW takes intermittently, but does not discuss the IW's response to this medication or the frequency it is being used. The request is not medically necessary.

Naproxen Sodium 550mg twice a day as needed for pain: 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): Anti-inflammatory medications.

Decision rationale: According to CA MTUS chronic pain guidelines, Naproxen is a non-steroidal anti-inflammatory drug that is used for the treatment of osteoarthritis. Further stated, non-steroidal anti-inflammatory agents are "recommended as an option for short term symptomatic relief" for the treatment of chronic low back pain. It is recommended that the lowest dose be utilized for a minimal duration of time. The documentation does not document a diagnosis of osteoarthritis. Improvement of symptoms specifically to the use of NSAIDs currently prescribed is not documented. The request is medically not necessary.

Ambien 10mg one tablet at bedtime as needed #15: 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), Pain Chapter, Insomnia treatment.

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

Decision rationale: Ambien is a sedative, hypnotic agent that is prescribed for sleep. This medication is recommended for short-term use and is not indicated in the treatment of chronic pain. Most recent documentation does not discuss the IW sleep patterns or reliance on this medication for sleep. The IW has been prescribed this medication for a minimum of 6 months which exceeds the recommendation of short-term use. As such, the request for Ambien is not medically necessary.

Ranitidine 150mg 1-2 tabs daily #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, GI symptoms & cardiovascular risk.

Decision rationale: According to CA MTUS, gastrointestinal protectant agents are recommended for patients that are at increased risk for gastrointestinal events. These risks include age >65, history of gastrointestinal bleeding or peptic ulcers, concomitant use of NSAIDs and corticosteroids or aspirin, or high dose NSAID use. The chart does not document any of these risk factors. Past medical history does not include any gastrointestinal disorders, there is no history of poor tolerance to NSAIDs documented and there are not abdominal examinations noted in the chart. The NSAID requested with this submission has been determined not medically necessary. The requesting provider did not provide a rationale or diagnosis to support this medication. Ranitidine is not medically necessary based on the MTUS guidelines.

TENS unit supplies: 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): Transcutaneous electrotherapy.

Decision rationale: The CA MTUS chronic pain guidelines recommend against the use of TENS units for the management of chronic pain. Additionally, the chronic pain management guidelines recommend against this therapy as a primary treatment, but support a one-month home based trial. The IW has had the unit for at least several months according the record. The documentation submitted supports that the IW uses the TENS frequently, but specific benefits related to the use of the unit are not discussed. The requesting provider states the IW has decreased narcotic and muscle relaxant use with this treatment, but does not give specific details regarding pain scale improvement or functional improvement. Without this documentation, the improvements from the unit are not known. Additionally, the request does not give specifics regarding which supplies are requested or the quantity of these supplies. As such, the request for TENS unit supplies are not medically necessary.