

Case Number:	CM15-0061067		
Date Assigned:	04/07/2015	Date of Injury:	10/30/2009
Decision Date:	06/01/2015	UR Denial Date:	03/17/2015
Priority:	Standard	Application Received:	03/31/2015

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: Physical Medicine & Rehabilitation

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 57 year old female, who sustained an industrial injury on 10/30/2009. The current diagnoses are possible lumbar discogenic pain/possible bilateral lumbar facet pain L4-L5, left worse than right, lumbar sprain/strain, left lumbosacral radicular pain L5-S, left shoulder pain and impingement, possible cervical discogenic pain, possible bilateral cervical facet pain C2-C3, C5-C6, left worse than right, possible cervical sprain/strain, left cervical radicular pain C6, and bilateral carpal tunnel syndrome. According to the progress report dated 2/11/2015, the injured worker complains of persistent, constant left shoulder pain (5-9/10) with radiation to the left upper extremity, improved neck pain (5-9/10) with radiation into bilateral shoulders and left upper extremity, and improved low back pain (6-9/10) with radiation to the left lower extremity. Treatment to date has included medication management, electrodiagnostic studies, X-rays, MRI studies, physical therapy, home exercise program, left shoulder injection, and epidural injections. The plan of care includes Norco, Lodine, Voltaren gel, Ultracin cream, Zanaflex, and Prilosec.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325 mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78-80.

Decision rationale: The request for Norco 10/325 mg #60 is not medically necessary. According to the California MTUS Guidelines, continuation of opioid therapy may be recommended for patients with ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. A pain assessment should include a current quantified pain, the least reported pain over the period since last assessment, the intensity of pain after taking the opioid, and how long pain relief lasts. 4 domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids including pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant drug related behaviors. The injured worker complained of constant neck pain with headaches. The injured worker rated the pain a 5/10 to 9/10 on a pain scale. The injured worker reported pain was effecting sleep and appetite. The injured worker reported that she was previously on pain medications and although they were beneficial, she was only getting short term pain relief. The documentation did not provide a complete and thorough pain assessment (to include the least reported pain over the period since last assessment, the intensity of pain after taking the medication, and how long pain relief lasts). The documentation did not provide sufficient evidence of significant objective functional deficits to warrant the opioid therapy at this time. Additionally, the documentation did not provide sufficient evidence of tried and failed nonopioid analgesics. Given the above, the request is not supported. As such, the request is not medically necessary.

Lodine 500 mg 60 with 5 refills: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 67-68.

Decision rationale: The request for Lodine 500 mg 60 with 5 refills is not medically necessary. According to the California MTUS, NSAIDs may be recommended as an option for short-term symptomatic relief. A Cochrane Review of the literature on drug relief for low back pain suggested that NSAIDs were no more effective than other drugs such as acetaminophen, narcotic analgesics, and muscle relaxants. The review also found that NSAIDs have more adverse effects than acetaminophen. The documentation did not provide sufficient evidence of a complete and thorough pain assessment, or sufficient evidence of significant objective functional limitations to warrant the NSAID at this time. Additionally, the documentation did not provide sufficient evidence of tried and failed initial therapy, including acetaminophen. Given the above, the request is not medically necessary.

Voltaren gel 2 tubes: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112.

Decision rationale: The request for Voltaren gel 2 tubes is not medically necessary. According to the California MTUS Guidelines, topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is little to no research to support the use of many of these compounded agents. Any compounded product that contains at least 1 drug (or drug class) that is not recommended, is not recommended. The use of these compounded agents requires knowledge of the specific analgesic effect of each agent, and how it will be useful for the specific therapeutic goal required. Voltaren gel may be indicated for the relief of osteoarthritis pain in joints that lend themselves to topical treatments (ankle, elbow, foot, hand, knee, and wrist). It has not been evaluated for treatment of the spine, hip, or shoulder. Given the above, the request is not supported. As such, the request is not medically necessary.

Ultracin topical cream: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111-113.

Decision rationale: The request for Ultracin topical cream is not medically necessary. According to the California MTUS Guidelines, topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is little to no research to support the use of many of these compounded agents. Any compounded product that contains at least 1 drug (or drug class) that is not recommended, is not recommended. The use of these compounded agents requires knowledge of the specific analgesic effect of each agent, and how it will be useful for the specific therapeutic goal required. Ultracin topical cream contains methyl salicylate, menthol, and capsaicin. According to the guidelines, capsaicin may be recommended only as an option in patients who have not responded or are intolerant to other treatments. The documentation did not provide sufficient evidence that the injured worker did not respond or was intolerant to other treatments. Given the above, the request is not supported. As such, the request is not medically necessary.

Zanaflex 4 mg #60 with 5 refills: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 63-66.

Decision rationale: The request for Xanax 4 mg #60 with 5 refills is not medically necessary. According to the California MTUS Guidelines, non-sedating muscle relaxants may be recommended for pain with caution of a second line option for short term treatment of acute exacerbations in patients with chronic low back pain. Muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in muscle back cases, they show no benefit beyond NSAIDs in pain and overall improvement. Also, there is no additional benefit shown in combination with NSAIDs. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. The documentation did not provide sufficient evidence of tried and failed first line treatment for acute exacerbations of chronic low back pain. Given the above, the request is not supported. As such, the request is not medically necessary.