

Case Number:	CM13-0002869		
Date Assigned:	11/08/2013	Date of Injury:	06/04/2011
Decision Date:	06/12/2014	UR Denial Date:	07/09/2013
Priority:	Standard	Application Received:	07/24/2013

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. The expert reviewer is Board Certified in Physical Medicine & Rehabilitation and is licensed to practice in Illinois. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 50-year-old male who reported an injury on 06/04/2011 after he was assaulted. The injured worker sustained an injury to his head, neck and low back. The injured worker's treatment history included multiple medications and psychological support. The injured worker was evaluated on 06/18/2013. It was documented that the injured worker's medications schedule includes Fentanyl patches, Norco 10/325 mg 6 per day, Flexeril 10 mg 3 times a day, Valium 10 mg twice per day, Promethazine 25 mg twice per day as needed for nausea, Restoril 30 mg 1 at night, and Lexapro 10 mg 1 at night. Physical objective findings included tenderness and heat over the mid part of the left trapezius with palpatory tenderness of the occipital protuberance of the left side. The injured worker's diagnoses included headache, post concussion syndrome, chronic low back pain, chronic fatigue, and cervical spine pain. The injured worker's treatment plan included trigger point injections, a 2 month supply of his medications, and a greater occipital nerve block. A letter of appeal dated 07/23/2013 documented that the injured worker had 40% pain relief resulting from medication usage that allowed him to walk, go shopping and do house work. It was documented that without medications the injured worker was not able to perform a home exercise program or even get out of bed. The treating provider indicated that the injured worker received symptom relief from Restoril, Promethazine, Flexeril and Valium and required ongoing use.

IMR ISSUES, DECISIONS AND RATIONALES

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

ONE NERVE BLOCK TO LEFT GREATER OCCIPITAL NERVE: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation International Association for the Study of Pain and World Cervicogenic Headache Society, (Haldeman, 2001), (Biondi, 2005), (Leone, 1998), (Aetna, 2006), (Bogduk, 2004), (Bovin, 1992) see also Greater Occipital Nerve Block, Therapeutic A.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Head Chapter, Greater Occipital Nerve Block (GONB).

Decision rationale: The requested nerve block to the left greater occipital nerve is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not address this request. Official Disability Guidelines state that greater occipital nerve blocks are under study and primarily used in the treatment of headaches. However, the mechanism of action is not understood and not scientifically supported. This treatment modality is not supported by guideline recommendations. There are no exceptional factors noted within the documentation to support extending treatment beyond guideline recommendations. As such, the requested greater occipital nerve block is not medically necessary or appropriate.

TRIGGER POINT INJECTION IN THE LEFT TRAPEZIUS: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation (Graff Radford, 2004), (Nelemans Cochrane, 2002).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Trigger Point Injections Page(s): 122.

Decision rationale: The requested trigger point injection to the left trapezius is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends the use of trigger point injections for palpable trigger points evidenced by a twitch response in the absence of radicular pain. The clinical documentation submitted for review does not provide any evidence that any palpable trigger points with a twitch response were identified upon examination. Therefore, the use of a trigger point injection would not be supported. As there are no exceptional factors to support extending treatment beyond guideline recommendations. As such, the requested trigger point injection in the left trapezius is not medically necessary or appropriate.

FENTANYL PATCHES 50 MCG, 2 MONTH SUPPLY: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-Going Management Page(s): 78.

Decision rationale: The requested fentanyl patches 50 mcg 2 month supply are not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends ongoing use of opioids be supported by a quantitative assessment of pain relief, documentation of functional benefit, evidence of monitoring for aberrant behavior and managed side effects. The clinical documentation submitted for review does not provide any evidence that the injured worker has significant pain relief resulting from medication usage. Although, the documentation does indicate that the injured worker is allowed functional benefit with medication usage, there is no documentation that the injured worker is monitored for aberrant behavior. Additionally, the request includes a 2 month supply which does not allow for timely re-evaluation and ongoing assessment to support the efficacy of this medication. Also, the request as it is submitted does not clearly identify a frequency or body part. Therefore, the appropriateness of the request itself cannot be determined. As such, the requested fentanyl patches 50 mcg two months supply are not medically necessary or appropriate.

NORCO 10/325 MG, 2 MONTH SUPPLY: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-Going Management Page(s): 78.

Decision rationale: The requested Norco 10/325 mg 2 month supply is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends ongoing use of opioids be supported by a quantitative assessment of pain relief, documentation of functional benefit, evidence of monitoring for aberrant behavior and managed side effects. The clinical documentation submitted for review does not provide any evidence that the injured worker has significant pain relief resulting from medication usage. Although, the documentation does indicate that the injured worker is allowed functional benefit with medication usage, there is no documentation that the injured worker is monitored for aberrant behavior. Additionally, the request includes a 2 month supply which does not allow for timely re-evaluation and ongoing assessment to support the efficacy of this medication. Also, the request as it is submitted does not clearly identify a frequency or body part. Therefore, the appropriateness of the request itself cannot be determined. As such, the requested Norco 10/325 mg 2 months supply is not medically necessary or appropriate.

PROMETHAZINE 25 MG, 2 MONTH SUPPLY: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Anti-Emetics.

Decision rationale: The requested promethazine 2 month supply is not medically necessary or appropriate. California Medical Treatment Utilization Scheduled does not address this type of

medication. Official Disability Guidelines do not support the use of antiemetics to manage nausea and vomiting related to medication usage. The clinical documentation submitted for review indicates that this medication is primarily being prescribed to the injured worker to assist with the management of nausea and vomiting related to medications. As this treatment is not supported by guideline recommendations and there are no exceptional factors to support extending treatment beyond guideline recommendations, continued use would not be supported. Also, the request as it is submitted is for a 2 month supply which does not allow for timely reassessment and re-evaluation of the efficacy of the medication. The request does not include a frequency of treatment. Therefore, the appropriateness of the request itself cannot be determined. As such, the requested promethazine 25 mg 2 month supply is not medically necessary or appropriate.

RESTORIL 30 MG, 2 MONTH SUPPLY: 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).

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

Decision rationale: The requested Restoril 30 mg 2 month supply is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not address this type of medication. Official Disability Guidelines recommend pharmacological intervention for injured workers who have insomnia complaints related to chronic pain. The clinical documentation submitted for review does not provide an adequate assessment of the injured worker's sleep hygiene to support the need for pharmacological intervention. Additionally, Official Disability Guidelines only recommend short courses of treatment of pharmacological intervention. The clinical documentation does indicate that the injured worker has been on this medication since at least 10/2012. Therefore, continued use would not be supported. The request includes a 2 month supply which does not allow for timely reassessment and evaluation of effectiveness. Also, the request itself does not provide a frequency of treatment. Therefore, the appropriateness of the request itself cannot be determined. As such, the requested Restoril 30 mg 2 month supply is not medically necessary or appropriate.

ONE (1) EFFEXOR 37.5MG: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Effexor (venlafaxine)..

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic pain and Anti-Depressants Page(s): 60 and 12.

Decision rationale: The requested Effexor 37.5 mg is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does recommend the use of antidepressants in the management of chronic pain. However, California Medical Treatment Utilization Schedule

also recommends continuing use of medications in the management of chronic pain be supported by documentation of functional benefit and evidence of pain relief. The clinical documentation submitted for review fails to provide any evidence that the injured worker receives any significant pain relief or functional benefit with the requested medication. Therefore, continued use would not be supported. Additionally, the request as it is submitted does not clearly identify a quantity or frequency of treatment. Therefore, the appropriateness of the request itself cannot be determined. Additionally, the clinical documentation reviewed does not provide any justification for the request. The requested medication is not part of the injured worker's medication schedule at the time of the request. As such, the requested Effexor 37.5 mg is not medically necessary or appropriate.

ONE (1) TRIAL OF BOTOX INJECTIONS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Botulinum Toxin (Botox, Myobloc)..

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Botulinum toxin (Botox®; Myobloc®) Page(s): 25.

Decision rationale: The requested trial of Botox injections is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not recommend the use of Botox injections in the management of chronic pain. It is supported in the treatment of cervical dystonia. The clinical documentation does not provide any evidence that the injured has any symptoms related to cervical dystonia. In addition, there was no justification provided for the request. As such, the requested trial of Botox injections is not medically necessary or appropriate.