

Case Number:	CM13-0025712		
Date Assigned:	06/09/2014	Date of Injury:	01/08/2002
Decision Date:	07/22/2014	UR Denial Date:	09/03/2013
Priority:	Standard	Application Received:	09/18/2013

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 California. 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 52-year-old female who reported an injury on 01/08/2002. The mechanism of injury was not provided for review. The injured worker ultimately underwent cervical fusion from C5-7. The injured worker was treated post surgically with meds to include Xanax, Norco, Soma, and Restoril. The injured worker was also treated with physical therapy, a TENS unit, and H-wave therapy. The injured worker was evaluated on 08/22/2013. Physical findings included tenderness to palpation over the cervical trapezial ridge with atrophy of the cervical paraspinal musculature and a pronounced bony structure secondary to atrophy. The injured worker's diagnoses included status post previous C5-7 anterior cervical discectomy and interbody fusion, cervical discogenic disease with radiculitis, chronic cervical spine pain/strain, status post posterior cervical fusion, and chronic anxiety. The injured worker's treatment plan included a new pain management physician, additional physical therapy, and a refill of medications to include Restoril 30 mg, Xanax 2 mg, Soma 1 three times a day, and Norco 10/325 mg. The injured worker was again evaluated on 01/15/2014. It was documented that the injured worker was participating in physical therapy that provided limited symptom relief. Physical findings included peri-incisional atrophy at the cervical neck and mild spasming of the cervical paraspinal musculature. The injured worker's treatment plan remained the same.

IMR ISSUES, DECISIONS AND RATIONALES

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

FOLLOW UP WITH [REDACTED] : Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 177.

Decision rationale: The requested followup with [REDACTED] is medically necessary and appropriate. The American College of Occupational and Environmental Medicine does recommend followup visits for injured workers who have failed to return to work at full or modified duty. The clinical documentation submitted for review does indicate that the requested physician has been the injured worker's primary treating physician for several months. Therefore, a followup visit with this physician would be appropriate in this clinical situation. As such, the requested followup with [REDACTED] is medically necessary and appropriate.

PHYSICAL THERAPY TWO (2) TIMES A WEEK FOR SIX (6) WEEKS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Active Therapy.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines PHYSICAL MEDICINE Page(s): 98-99.

Decision rationale: The requested physical therapy 2 times a week for 6 weeks is not medically necessary or appropriate. The clinical documentation submitted for review does indicate that the injured worker has previously participated in physical therapy. California Medical Treatment Utilization Schedule recommends that injured workers be transitioned into a home exercise program to maintain improvement levels obtained during skilled physical therapy. The clinical documentation submitted for review does not provide any evidence that the patient is participating in a home exercise program. Therefore, a short course of treatment would be recommended to support reestablishing a home exercise program for the injured worker. However, 12 visits would be considered excessive. As such, the requested physical therapy 2 times a week for 6 weeks is not medically necessary or appropriate. Furthermore, the request as it is submitted does not specifically identify a body part. In the absence of this information, the appropriateness of the request cannot be determined.

REFILL RESTORIL 30 MG #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines.

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.

Decision rationale: The requested refill of Restoril 30 mg #30 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not specifically address this

medication. The Official Disability Guidelines do not recommend the extended use of this medication for management of insomnia complaints related to chronic pain. The clinical documentation submitted for review does indicate that the injured worker has been on this medication since at least 05/2013. Therefore, continued use would not be supported. Additionally, the submitted documentation fails to provide an adequate assessment of the patient's sleep hygiene to support the need for pharmacological intervention for this diagnosis. Furthermore, the request as it is submitted does not provide a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested refill of Restoril 30 mm #30 is not medically necessary or appropriate.

XANAX 2 MG #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines BENZODIAZEPINES Page(s): 24.

Decision rationale: The requested Xanax 2 mg #90 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not recommend the extended use of benzodiazepines in the management of chronic pain. California Medical Treatment Utilization Schedule recommends use be limited to 4 weeks as there is a high incidence of psychological and physiological dependence. The clinical documentation submitted for review did not provide any exceptional factors to support extending treatment beyond guideline recommendations. Furthermore, the request as it is submitted did not provide a frequency of treatment. Therefore, the appropriateness of the request itself cannot be determined. As such, the requested Xanax 2 mg #90 is not medically necessary or appropriate.

SOMA #80: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants ,page 29.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MUSCLE RELAXANTS Page(s): 63.

Decision rationale: The requested Soma #80 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not support the long term use of muscle relaxants in the management of chronic pain. California Medical Treatment Utilization Schedule recommends use be limited to 2 to 3 weeks for an acute exacerbation. The clinical documentation submitted for review does indicate that the injured worker has been on this medication since at least 05/2013. Therefore, continued use would not be supported. Furthermore, the request as it is submitted does not provide a dosage or frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Soma #80 is not medically necessary or appropriate.

NORCO 10/325 MG #240: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, pages 78,91.

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 #240 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends the ongoing use of opioids in the management of chronic pain be supported by documented functional benefit, a quantitative assessment of pain relief, managed side effects, and evidence that the injured worker is monitored for aberrant behavior. The clinical documentation submitted for review does not provide any evidence that the injured worker has had any significant increase in function or decrease in pain resulting from the use of this medication. Additionally, the clinical documentation fails to provide any evidence that the injured worker is monitored for aberrant behavior. Additionally, the clinical documentation submitted for review fails to provide a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested 10/325 mg #240 is not medically necessary or appropriate.