

Case Number:	CM13-0028281		
Date Assigned:	11/22/2013	Date of Injury:	01/05/2007
Decision Date:	09/11/2014	UR Denial Date:	08/30/2013
Priority:	Standard	Application Received:	09/23/2013

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 Nevada. 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 61 year-old female who was reportedly injured on January 5, 2007. The mechanism of injury is not listed in these records reviewed. The most recent progress note dated April 3, 2013, indicates that there are ongoing complaints of neck pain with bilateral upper extremity involvement. The physical examination demonstrated tenderness to palpation, and reviewed range of motion of the cervical spine and bilateral upper extremity, an inability to perform heel and toe walking, a reduced lumbar spine range of motion. Diagnostic imaging studies objectified were not presented. Previous treatment includes cervical epidural steroid injections, multiple medications and other pain management interventions. A request was made for multiple medications and was not certified in the pre-authorization process on August 30, 2013.

IMR ISSUES, DECISIONS AND RATIONALES

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

NORCO 10/325 PRN #240: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-78, 88, 91.

Decision rationale: As outlined in the California Medical Treatment Utilization Schedule, this medication is indicated for the management of moderate to severe breakthrough pain. Dispensing indication indicate that this is a chronic, indefinite use of around-the-clock medication. Furthermore, when noting the pain complaints offered and the physical examination findings, there was no data to suggest that this medication has any efficacy whatsoever. As such, with no parameters noted of any success with this medication the request is not medically necessary.

PRILOSEC 20MG BID #60: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68.

Decision rationale: As noted in the California Medical Treatment Utilization Schedule, this is a protein pump inhibitor useful for the treatment of gastroesophageal reflux disease and is considered a gastric protectant. When noting the date of injury and the progress of presented there are no complaints of any gastritis type symptoms or irritation that would warrant such a medication. When considering the amount of time that this medication has been employed, tempered by the lack of any complaints it is clear that there is no clinical indication for the continued use of this medication therefore the request is not medically necessary.

ATIVAN 1MG PRN QHS #10: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: This medication is a benzodiazepine that is not recommended for long-term use because of the unproven long-term efficacy and a significant risk of psychological and physical dependence upon this medication or even possibly addiction. The recommendation utilization profile is no more than 4 weeks. Therefore, when noting the date of injury, the current complaints, the most recent physical examinations (greater than one year ago), there was no demonstrated efficacy or clinical indication for the continued use of this medication therefore the request is not medically necessary.

ZOLOFT 50MG 4 TABS QAM #120: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 13-16,107.

Decision rationale: This is an antidepressant medication (SSRI) and is somewhat controversial based on the controlled trials. It is not clear if this medication is being used to address the depression (and not has been outlined in the progress notes reviewed) or some other off label use. Therefore, based on the lack of clinical information there is insufficient data to support the medical necessity of this medication therefore the request is not medically necessary.

FIORICET BID #60: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Page(s): 23.

Decision rationale: As outlined in the American College of Occupational and Environmental Medicine guidelines, this is a barbiturate containing analgesic agent (PCA) that is not recommended for chronic pain. The potential for drug dependence is high, there is no evidence to demonstrate how this affects the analgesic properties, and given the ongoing complaints of pain the efficacy of this medication has not been established therefore the request is not medically necessary.

VITAMIN B12 INJECTION ICC IM WEEKLY #4 AMPS: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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 updated July, 2014.

Decision rationale: It is noted that this medication is "not recommended." There is no established efficacy in treating peripheral neuropathy with the use of these medications. Therefore, when noting the lack of clinical data to support the evidence-based medicine profile, noting the ongoing complaints of pain and there was no noted efficacy with the utilization of this preparation the medical necessity has not been established. Therefore the request is not medically necessary.

AMBIEN 10MG QHS PRN #15: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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.

Decision rationale: This medication is a short acting non-benzodiazepine hypnotic preparation which is approved for the short-term treatment of insomnia. The recommendations limited to no more than 6 weeks. While noting the sleep hygiene is a crucial part of a pain control protocol, there is no discussion about the sleep hygiene noted in the progress notes. As such, the efficacy of this medication has not been established. Therefore, when noting the recommendations outlined in the nationally published literature tempered by the lack of data presented in the progress notes there is insufficient clinical information presented to support the medical necessity of this medication. Therefore, the request is not medically necessary.

NEUROSURGEON POST-SURGERY FOLLOW UP WITH [REDACTED]: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM, CHAPTER 7, 127.

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

Decision rationale: When noting each of the treatments rendered, the ongoing complaints, there is a clear clinical indication that an appropriate follow-up evaluation should be completed. Therefore, I do believe that an additional follow up evaluation is medically necessary.