

Case Number:	CM13-0048346		
Date Assigned:	12/27/2013	Date of Injury:	07/26/1996
Decision Date:	07/02/2014	UR Denial Date:	10/16/2013
Priority:	Standard	Application Received:	11/05/2013

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 and 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 patient is a 50 year-old male that sustained an injury to his left foot on 7/26/1996 from a fallen coin machine while employed by [REDACTED]. The requests under consideration include Percocet 10/325mg, Valium 10mg 1 po prn #30, Water therapy 2 per week x 6 weeks (total 12), and Tegaderm patches #120. The patient is s/p surgery with hardware placement from a left 4th metatarsal and navicular fracture from this 1996 injury. The report of 9/23/13 from NP for provider noted patient with chronic left foot and low back pain described as burning sensation on top and underneath the foot. Pain was rated at 9/10 on a regular basis with sharp stabbing mid back pain radiating to bilateral legs and feet associated with numbness and tingling. The last physical therapy was about a year ago with significantly helped. The patient has sleeping difficulty and has used Ambien and Valium combination. An exam of the lumbar spine showed tenderness across lumbar area, range include ff/ext/lateral bending of 30/5/20 degrees, negative straight leg raises, left foot hypersensitive with dorsiflex 15 degrees and can barely extend or flex toes, right Achilles reflex trace/absent on left, diffuse motor weakness throughout at 4/5 with left foot at 3.5/5 and the patient is unable to heel or toe walk. The patient stands at 5'7" weighing 213 pounds. Medications list OxyContin, Ambien, Valium, Klonopin, Prednisone, Fentanyl patch. A review of the 7/17/13 report of stated the patient had treatment plan for Water therapy, Fentanyl patch, Tegaderm, Valium and Percocet without objective findings documented. A request for Percocet was modified for one month supply and the Valium, Tegaderm dressing, and Water therapy were denied on 10/16/13 citing guidelines criteria and lack of medical necessity.

IMR ISSUES, DECISIONS AND RATIONALES

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

PERCOCET 10/325MG: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 92.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96.

Decision rationale: Per the California MTUS Guidelines cited, opioid use in the setting of chronic, non-malignant, or neuropathic pain is controversial. Patients on opioids should be routinely monitored for signs of impairment and use of opioids in patients with chronic pain should be reserved for those with improved functional outcomes attributable to their use, in the context of an overall approach to pain management that also includes non-opioid analgesics, adjuvant therapies, psychological support, and active treatments (e.g., exercise). Submitted documents show no evidence that the treating physician is prescribing opioids in accordance to change in pain relief, functional goals with demonstrated improvement in daily activities, decreased in medical utilization or change in work status. There is no evidence presented of random drug testing or utilization of pain contract to adequately monitor for narcotic safety, efficacy, and compliance. The California MTUS provides requirements of the treating physician to assess and document for functional improvement with treatment intervention and maintenance of function that would otherwise deteriorate if not supported. From the submitted reports, there is no demonstrated evidence of specific functional benefit derived from the continuing use of opioids with persistent severe pain. The Percocet 10/325mg is not medically necessary and appropriate.

VALIUM 10MG, #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 23.

Decision rationale: Valium is an anti-anxiety medication in the benzodiazepine family and like other benzodiazepines, act by enhancing the effects of gamma-aminobutyric acid (GABA) in the brain. GABA is a neurotransmitter (a chemical that nerve cells use to communicate with each other) which inhibits many of the activities of the brain. It is believed that excessive activity in the brain may lead to anxiety or other psychiatric disorders. Valium also is used to prevent certain types of seizures. Valium is used for the short-term relief of the symptoms of anxiety. It is used for certain types of seizures, specifically petit mal seizures, akinetic seizures, and myoclonus, as well as Lennox-Gastaut syndrome. Submitted reports have not adequately addressed the indication for Valium's continued use for the chronic 1996 injury nor is there documented functional efficacy from treatment already rendered. Valium 10mg 1 po prn #30 is not medically necessary and appropriate.

WATER THERAPY 2 TIMES A WEEK FOR 6 WEEKS QTY: 12: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic Therapy Page(s): 22.

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

Decision rationale: Aquatic Therapy does not seem appropriate as the patient has received land-based physical therapy. There is no records indicating intolerance of treatment, incapable of making same gains with land-based program nor is there any medical diagnosis or indication to require aqua therapy at this time. The patient is not status-post recent lumbar or knee surgery nor is there diagnosis of morbid obesity requiring gentle aquatic rehabilitation with passive modalities and should have the knowledge to continue with functional improvement with a home exercise program. The patient has completed formal sessions of PT and there is nothing submitted to indicate functional improvement from treatment already rendered. There is no clear measurable evidence of progress with the PT treatment already rendered including milestones of increased ROM, strength, and functional capacity. Review of submitted physician reports show no evidence of functional benefit, unchanged chronic symptom complaints, clinical findings, and work status. Submitted reports have not adequately demonstrated the indication to support for the aquatic therapy. The water therapy 2 per week x 6 weeks (total 12) is not medically necessary and appropriate.

TEGADERM 20MG, #120: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back Chapter, Wound Dressings.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: There is no guideline to address the non-specific use of Tegaderm.

Decision rationale: Submitted reports have not adequately demonstrated the medical indication or necessity for Tegaderm, an adherent bandage dressing. There are no open wounds, abrasions, or recent surgical areas documented requiring Tegaderm dressing. It is not clearly presented; however, the patient has a Fentanyl patch prescription which should be self-adherent and not a medical standard practice necessitating an additional Tegaderm dressing for active treatment. The Tegaderm patches #120 is not medically necessary and appropriate.