

Case Number:	CM13-0057716		
Date Assigned:	12/30/2013	Date of Injury:	10/30/2010
Decision Date:	05/15/2014	UR Denial Date:	11/11/2013
Priority:	Standard	Application Received:	11/25/2013

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, has a subspecialty in Pain Medicine and is licensed to practice in Texas and Ohio. 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 51-year-old female who reported an injury on 01/30/2010, a slip and fall. The injured worker reportedly sustained an injury to her neck and low back. The injured worker's treatment history included physical therapy, acupuncture, epidural steroid injections, and multiple medications. The injured worker was evaluated on 10/09/2013. It was noted that the injured worker had ongoing pain complaints. Physical findings included reduced range of motion of the cervical spine with facet tenderness and decreased sensation in the C5 through the C7 dermatomal distributions. Evaluation of the bilateral shoulders documented positive impingement bilaterally with painful range of motion described as 90 degrees in forward flexion and abduction. Evaluation of the bilateral wrists and hands revealed a positive Tinel's sign and Phalen's test and Durkan's compression test bilaterally. Evaluation of the lumbar spine revealed tenderness to palpation and spasming with painful range of motion and a positive straight leg raising test bilaterally with decreased sensation in the L4 through S1 dermatomal distribution bilaterally. The injured worker's diagnoses included cervical discogenic disease, cervical facet arthropathy, chronic cervical spine sprain/strain, lumbar discogenic disease, chronic low back pain, bilateral shoulder impingement, bilateral shoulder subacromial bursitis, bilateral carpal tunnel syndrome, chronic pain syndrome. The injured worker's treatment plan included continued use of a TENS unit, and continued use of medications to include Norco 10/325 mg, Neurontin, Flexeril, and Restoril.

IMR ISSUES, DECISIONS AND RATIONALES

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

NORCO 10/325MG #180: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-Going Management. .

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 #180 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 documentation of functional benefit, a quantitative assessment of pain relief, managed side effects, and evidence that the patient is monitored for aberrant behavior. The clinical documentation submitted for review does not provide any evidence to support the efficacy of this medication. There is no quantitative assessment or documentation of functional benefit to support continued use. Additionally, there is no documentation that the injured worker is monitored for aberrant behavior. Also, the request as it is submitted does not provide a frequency of treatment. Therefore, the appropriateness of the request itself cannot be determined. As such, the requested Norco 10/325 mg #180 is not medically necessary or appropriate

RESTORIL 30MG #30: Upheld

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

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 Treatments.

Decision rationale: The requested Restoril 30 mg #30 is not medically necessary or appropriate. The request as it is submitted appears to have a typographical error. The requested medication Restoril is for the treatment of insomnia related to chronic pain. California Medical Treatment Utilization Schedule does not address insomnia treatments. The clinical documentation submitted for review does not provide a treatment history for this medication. Official Disability Guidelines recommend short durations of usage of this medication in the management of insomnia related to chronic pain after non-pharmacological interventions have failed to resolve the patient's symptoms. The injured worker's most recent clinical evaluation does not provide an adequate assessment of the injured worker's sleep hygiene to support the need for pharmacological intervention for insomnia complaints. There is no documentation that the injured worker has failed to respond to nonpharmaceutical interventions. Therefore, the use of this medication would not be supported. Additionally, the request as it is submitted does not clearly identify a frequency of treatment. Therefore, the appropriateness of the request itself cannot be determined. As such, the requested Restoril 30 mg #30 is not medically necessary or appropriate.

FLEXERIL 10MG (QUANTITY UNSPECIFIED): Upheld

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

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

Decision rationale: The requested Flexeril 10 mg quantity unspecified is not medically necessary or appropriate. The clinical documentation submitted for review does indicate that the injured worker has been on this medication for an extended duration of time. California Medical Treatment Utilization Schedule recommends muscle relaxants for short durations of treatment for acute exacerbations of chronic pain. The clinical documentation submitted for review does not indicate that the injured worker was having an acute exacerbation. Therefore, the need for this medication is not clearly determined. As the injured worker has already been on this medication for an extended duration, continued use would not be supported. Also, the request as it is submitted does not provide a quantity or frequency of treatment. Therefore, the appropriateness of the request itself cannot be determined. As such, the requested Flexeril 10 mg quantity unspecified is not medically necessary or appropriate.