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| Case Number: | CM13-0066130 | | |
| Date Assigned: | 03/26/2014 | Date of Injury: | 11/07/2004 |
| Decision Date: | 06/30/2014 | UR Denial Date: | 11/14/2013 |
| Priority: | Standard | Application Received: | 12/16/2013 |

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 Texas. 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 36-year-old female who reported injury on 11/07/2004. The clinical documentation indicated the injured worker was utilizing Ambien 10 mg, Neurontin 400 mg, Skelaxin 800 mg, Motrin 800 mg, and oxycodone hydrochloride 15 mg in 06/2013. The documentation of 11/06/2013 indicated the injured worker's pain level had increased since the last visit. The quality of sleep was fair and the activity level had increased. The diagnoses included carpal tunnel syndrome, elbow pain, reflex sympathetic dystrophy, upper limb and wrist pain. The treatment plan included a refill of the medications that were previously mentioned. The oxycodone was to be 4 times a day for breakthrough pain. The urine drug screen was negative. There was a request for a continuation of Skelaxin as needed for muscle spasms, Ambien for sleep initiation and maintenance, and Motrin for anti-inflammatory pain relief.

IMR ISSUES, DECISIONS AND RATIONALES

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

OXYCODONE HCI 15MG #120: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, OPIOIDS, ONGOING MANAGEMENT, 91

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines Medications for Chronic pain, page 60, ongoing managem.

Decision rationale: The California MTUS Guidelines recommend opiates for the treatment of chronic pain. There should be documentation of objective functional improvement and objective decrease in pain, and documentation that the injured worker is monitored for aberrant drug behavior and side effects. The clinical documentation submitted for review indicated the injured worker had been utilizing the medication since 06/2013. There was a lack of documentation of objective functional improvement and an objective decrease in pain. There was documentation the injured worker is being monitored for aberrant drug behavior and side effects. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for oxycodone hydrochloride 15 mg #120 is not medically necessary.

AMBIEN 10MG #30: 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 Zolpidem

Decision rationale: The Official Disability Guidelines do not recommend zolpidem for long term use. It is recommended for 2 to 6 weeks. The clinical documentation submitted for review indicated the injured worker had been utilizing the medication since 06/2013. There was a lack of documented efficacy for the requested medication. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Ambien 10 mg #30 is not medically necessary.

MOTRIN 800MG #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, NSAIDS,

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 67.

Decision rationale: The California MTUS Guidelines recommend NSAIDs for the short term symptomatic relief of pain. There should be documentation of objective functional improvement and an objective decrease in pain. The clinical documentation submitted for review indicated the injured worker had been utilizing the medication for greater than 5 months. There was a lack of documentation of objective functional benefit and an objective decrease in pain. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Motrin 800 mg #30 is not medically necessary.

SKELAXIN 800MG #90: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, MUSCLE RELAXANTS,

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

Decision rationale: The California MTUS Guidelines recommend muscle relaxants as a second line option for the short term treatment of pain. Their use is recommended for less than 3 weeks. There should be documentation of objective functional improvement. The clinical documentation submitted for review indicated the injured worker had been utilizing the medication for greater than 5 months. There was a lack of documentation of objective functional benefit that was received. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Skelaxin 800 mg #90 is not medically necessary.