MAXIMUS Federal Services

Case Number:	CM13-0070362		
Date Assigned:	01/03/2014	Date of Injury:	09/20/2005
Decision Date:	06/11/2014	UR Denial Date:	11/27/2013
Priority:	Standard	Application Received:	12/24/2013

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 49-year-old male who reported an injury on 09/20/2005. The mechanism of injury was not provided for review. The injured worker ultimately underwent fusion surgery at the L5-S1 in 03/2006. The injured worker's treatment history included several modalities, which included acupuncture, physical therapy, multiple medications, and injections. The patient underwent spinal cord implantation to assist with pain control and functional improvement. The injured worker also underwent psychological support. The injured worker was monitored for aberrant behavior with urine drug screens. The report was evaluated on 12/13/2013. It was documented that the injured worker's medication schedule included MS Contin 100 mg, Fioricet 3 to 4 times a day, Topamax 25 mg, Norco 10/325 mg, Promolaxin 3 times a day, Acetadryl 1 tablet every night as needed, and ibuprofen 800 mg 3 to 4 times a day as needed. It was documented that the injured worker had medication-induced gastritis that responded to Prilosec. It was documented that the injured worker was prescribed Acetadryl for insomnia complaints. A request was made for refill of medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 BILATERAL OCCIPITAL NERVE BLOCK, BETWEEN 11/13/2013 AND 1/24/2014:
Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Head, Neck & Upper back (Acute & chronic).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back Chapter, Greater Occipital Nerve Block, Therapeutic.

Decision rationale: The California Medical Treatment Utilization Schedule does not address this request. The Official Disability Guidelines (ODG) does not recommend this procedure, as it is still considered under study and is not supported by significant scientific evidence. The ODG recommends that this may be indicated as an intervention for some types of migraine headaches. However, clinical documentation does not clearly identify that the injured worker has failed to respond to all other lesser invasive treatments. There are no exceptional factors noted within the documentation to support extending treatment beyond guideline recommendations. As such, the requested bilateral occipital nerve block is not medically necessary or appropriate. The request as it is submitted does not clearly identify a frequency of treatment. Therefore, the request is not medically necessary and appropriate.

1 PRESCRIPTION FOR MS CONTIN 100MG #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Section Opioids, On-Going Management Page(s): 78.

Decision rationale: The California Medical Treatment Utilization Schedule recommends continued 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 injured worker is monitored for aberrant behavior. The clinical documentation submitted for review does indicate that the injured worker is monitored for aberrant behavior. However, there is no specific documentation of a quantitative assessment of pain relief to support the efficacy of this medication. Additionally, specific functional benefit is not provided within the documentation. The clinical documentation submitted for review does indicate that the injured worker has been taking this medication since at least 09/2012. Therefore, continued use would need to be supported by ongoing documentation of pain relief and functional benefit. As such, the requested prescription of MS Contin 100 mg #120 is not medically necessary or appropriate.

1 PRESCRIPTION FOR NORCO 10/325MG #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Section Opioids, On-Going Management Page(s): 78.

Decision rationale: The California Medical Treatment Utilization Schedule recommends continued 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 injured worker is monitored for aberrant behavior. The clinical documentation submitted for review does indicate that the injured worker is monitored for aberrant behavior. However, there is no specific documentation of a quantitative assessment of pain relief to support the efficacy of this medication. Additionally, specific functional benefit is not provided within the documentation. The clinical documentation submitted for review does indicate that the injured worker has been taking this medication since at least 09/2012. Therefore, continued use would need to be supported by ongoing documentation of pain relief and functional benefit. As such, the requested prescription of Norco 10/325 mg #120 is not medically necessary or appropriate. The request as it is submitted does not clearly identify a frequency of treatment. Therefore, the request is not certified.

1 PRESCRIPTION FOR TOPAMAX 50MG #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Section Anti-epilepsy drugs (AEDs)..

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain and Anti-Epileptics Page(s): 60 and 16.

Decision rationale: The clinical documentation submitted for review does indicate that the injured worker has been taking this medication since at least 09/2012. The California Medical Treatment Utilization Schedule (MTUS) does recommend anticonvulsants as a first-line medication in the management of chronic pain. However, the California MTUS recommends ongoing use of medications in the management of chronic pain be supported by documentation of functional benefit and documentation of functional increases. The clinical documentation submitted for review fails to provide a quantitative assessment of pain relief or specific evidence of functional improvement related to medication usage. Therefore, continued use of this medication would not be supported. As such, the requested prescription of Topamax 50 mg #30 is not medically necessary or appropriate. The request as it is submitted does not clearly identify a frequency of treatment. Therefore, the request is not certified.

1 PRESCRIPTION FOR ACETADRYL: Upheld

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

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 clinical documentation submitted for review does indicate that the injured worker has been taking this medication for an extended duration of time. The California MTUS does not address this request. The Official Disability Guidelines (ODG) recommends sedating antihistamines for short durations in the management of insomnia related to chronic pain. The clinical documentation does indicate that the injured worker has been using this medication on and off for a long period of time. However, significant decrease in insomnia-related symptoms is not clearly identified within the documentation. Therefore, continued use would not be supported. As such, the requested 1 prescription for Acetadryl is not medically necessary or appropriate. The request as it is submitted does not clearly identify a frequency of treatment. Therefore, the request is not certified.