

Case Number:	CM14-0000142		
Date Assigned:	05/07/2014	Date of Injury:	08/07/2006
Decision Date:	07/10/2014	UR Denial Date:	12/24/2013
Priority:	Standard	Application Received:	12/31/2013

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,, has a subspecialty in Sports Medicine, 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 43-year-old who reported an injury on August 7, 2006. The mechanism of injury was not specifically stated. Current diagnoses include right shoulder sprain, right carpal tunnel syndrome, and low back pain. The injured worker was evaluated on November 14, 2013. The injured worker reported lower back and right shoulder pain rated 8/10 without medication. Current medications include Duragesic patch 50 mcg, Roxicodone 30 mg, and Restoril 30 mg. Physical examination was not provided on that date. Treatment recommendations at that time included continuation of current medication.

IMR ISSUES, DECISIONS AND RATIONALES

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

RESTORIL 30 MG: Upheld

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

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

Decision rationale: The Chronic Pain Medical Treatment Guidelines state benzodiazepines are not recommended for long term use because long term efficacy is unproven and there is a risk of

dependence. There is no frequency or quantity listed in the current request. The request for Restoril 30 mg is not medically necessary or appropriate.

DURAGESIC PATCHES 50 MCG: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 44.

Decision rationale: The Chronic Pain Medical Treatment Guidelines state fentanyl transdermal system is not recommended as a first line therapy. Duragesic is indicated in the management of chronic pain in patients who require continuous opioid analgesia for pain that cannot be managed by other means. There is no evidence of a failure of first line therapy. There is also no frequency or quantity listed in the current request. The request for duragesic patches, 50 mcg, is not medically necessary or appropriate.

ROXICODONE 30 MG: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

Decision rationale: The Chronic Pain Medical Treatment Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. There is no documentation of a failure to respond to non-opioid analgesics. There is also no frequency or quantity listed in the current request. The request for Roxicodone 30 mg is not medically necessary or appropriate.