

Case Number:	CM14-0001206		
Date Assigned:	01/22/2014	Date of Injury:	03/01/2001
Decision Date:	06/12/2014	UR Denial Date:	12/04/2013
Priority:	Standard	Application Received:	01/03/2014

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 injured worker is a 52 year old female who reported an injury on 03/01/2001 secondary to unknown mechanism of injury. The injured worker was evaluated on 10/22/2013 for reports of pain to the left hip, left leg, right arm and right elbow. The injured worker rated the pain to the right elbow at 7/10, the left hip at 5/10 and left leg and right arm at 7/10. The exam noted tenderness to palpation over the sub occipital regions bilaterally and bilateral trapezius spasm. The cervical range of motion was noted as bilateral lateral flexion at 25, flexion at 60, extension at 25, right rotation at 30 and left rotation at 15. There was swelling in the right elbow and wrist with tenderness to palpation and limited range of motion noted. There was tenderness to the lumbar region with spasm and a positive straight leg raise noted. The lumbar range of motion was noted as bilateral lateral flexion at 10, flexion at 70 and extension at 10. There was also decreased sensation to the lateral aspect of the leg with tenderness with pain radiating to the left foot top and bottom and all toes. The diagnoses included lumbosacral disc degeneration, pain in limb, lumbosacral neuritis and adhesive capsulitis of the right shoulder. The treatment plan included a toradol injection, current medication therapy and ice/heat therapy. The request for authorization was not in the documentation provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

ALPRAZOLAM 0.5MG #30: Upheld

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

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

Decision rationale: The request for Alprazolam 0.5mg #30 is not medically necessary. The California MTUS Guidelines does not recommend the use of benzodiazepines for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. The injured worker has been prescribed Alprazolam since at least 10/11/2012. This time frame exceeds the amount of time recommended. Therefore, based on the documentation provided, the request is not medically necessary.

KETOPROFEN 50MG #90: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 67-73.

Decision rationale: The request for Ketoprofen 50mg #90 is not medically necessary. The California MTUS Guidelines state the use of NSAIDs is recommended as an option for short-term symptomatic relief of back pain. The injured worker has also been prescribed an ketoprofen since at least 10/11/2012. This exceeds the time frame to be considered short-term. There is also a significant lack of objective evidence of the efficacy of the prescribed medication. Therefore, based on the documentation provided, the request is not medically necessary.

OYCODONE 15MG #60: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-95.

Decision rationale: The request for Oycodone 15mg #60 is not medically necessary. The California MTUS Guidelines recommend the use of opioids for the on-going management of chronic low back pain. The ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should be evident. There is a lack of evidence of an objective assessment of risk for aberrant drug use behavior and side effects. Therefore, based on the documentation provided, the request is not medically necessary.