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| Case Number: | CM14-0002393 | | |
| Date Assigned: | 01/24/2014 | Date of Injury: | 04/12/2007 |
| Decision Date: | 06/25/2014 | UR Denial Date: | 12/30/2013 |
| Priority: | Standard | Application Received: | 01/07/2014 |

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 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 62-year-old male who reported an injury on 04/12/2007. The mechanism of injury was not provided for review. The injured worker's treatment history included failed back surgery, epidural steroid injections, multiple medications, and a spinal cord stimulator trial. The injured worker was evaluated on 12/16/2013. It was documented that the injured worker had an average pain score of an 8/10 that was reduced to a 5/10 with medications. It was documented that the injured worker was able to participate in activities of daily living inside the home due to medication usage. The injured worker's medications included Trazodone Hydrochloride, Percocet, Klonopin, Lunesta, and Vitamin B complex. The injured worker's diagnoses included low back pain, postlaminectomy syndrome of the lumbar spine, neck pain, cervical strain, degenerative changes of the lumbar spine, knee pain, and chronic pain syndrome. A request was made for a refill of medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 PRESCRIPTION OF KLONOPIN 0.5MG #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, BENZODIAZEPINES.

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

Decision rationale: The requested 1 Prescription of Klonopin 0.5MG #60 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not recommend the long term use of benzodiazepines in the management of chronic pain. The clinical documentation does indicate that the injured worker has been in this medication since at least 09/2013. California Medical Treatment Utilization Schedule does not recommend treatment duration of this type of medication to exceed 4 weeks, due to a high incidence of psychological and physiological dependency. The clinical documentation does not provide any exceptional factors to support extending treatment beyond guideline recommendations. Furthermore, the request does not provide a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested 1 prescription of Klonopin 0.5mg #60 is not medically necessary or appropriate.

1 PRESCRIPTION OF LUNESTA 3MG #30 WITH 4 REFILLS: 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 requested 1 prescription of Lunesta 3mg #30 with 4 refills is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does not address this request. The Official Disability Guidelines recommend Lunesta as a long term treatment option in the management of insomnia related to chronic pain. However, the clinical documentation submitted for review does not provide an adequate assessment of the injured worker's sleep hygiene to support continued use of this medication. Additionally, the requested 4 refills does not allow for timely re-assessment to establish the efficacy and support continued use. Furthermore, the request as it is submitted does not clearly define a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested 1 prescription of Lunesta 3mg #30 with 4 refills is not medically necessary or appropriate.

1 PRESCRIPTION OF TRAZODONE HCL 50MG #60 WITH 4 REFILLS: 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 Treatment

Decision rationale: The requested 1 Prescription of Trazodone HCL 50mg #60 with 4 refills is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does not address this request. Official Disability Guidelines do not recommend the extended use of Trazodone as a pharmacological treatment of insomnia related to chronic pain. The clinical documentation submitted for review does indicate that the injured worker is prescribed this medication due to insomnia complaints. An adequate assessment of the injured worker's sleep hygiene was not provided. Furthermore, the request does not include a frequency of treatment. In the absence of this information, the appropriateness of the request cannot be determined. Additionally, the request includes 4 refills. This does not allow for timely re-assessment or evaluation to determine efficacy and support continued use. As such, the requested 1 prescription of Trazodone HCL 50mg #60 with 4 refills is not medically necessary or appropriate.

1 PRESCRIPTION OF PERCOCET 10/325MG #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, OPIOIDS FOR CHRONIC PAIN.

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

Decision rationale: The requested 1 prescription of Percocet 10/325mg #30 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 a quantitative assessment of pain relief, managed side effects, documentation of functional benefit, and evidence that the injured worker is monitored for aberrant behavior. The clinical documentation submitted for review does support that the injured worker has a reduction in pain that allows for increased participation in activities of daily living. However, the clinical documentation fails to provide any evidence that the injured worker is monitored for aberrant behavior. Furthermore, the request as it is submitted does not clearly define a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested 1 Prescription of Percocet 10/325mg #30 is not medically necessary or appropriate.