MAXIMUS Federal Services

Case Number:	CM14-0008869		
Date Assigned:	03/03/2014	Date of Injury:	08/14/2004
Decision Date:	10/01/2014	UR Denial Date:	01/17/2014
Priority:	Standard	Application Received:	01/22/2014

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 Orthopedic Surgery and is licensed to practice in Mississippi. 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 71-year-old female who was reportedly injured on 08/14/2004, with no specific mechanism of injury identified, but continues to have substernal admit thoracic pain. An intrathecal pump is being employed. The pain level continues to be 9/10. The physical examination noted tenderness in the cervical region of the spine. A decrease in cervical and thoracic range of motion is reported. Sensation is intact. A slight weakness in the extensor hallucis longus is reported. Comorbidities include migraine headache, lumbar radiculopathy, the gender joint disease right knee and cervical facet joint arthropathy. A previous request for this narcotic had not been certified. Multiple previous progress notes indicate unending, complaints of pain with no improvement irrespective of the medication protocols employed.

IMR ISSUES, DECISIONS AND RATIONALES

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

DILAUDID 8MG #240: 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, ,

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines Page(s): 86/127.

Decision rationale: Under the Chronic Pain Medical Treatment Guidelines page 86, this is a short-acting opioid medication. There is no reported efficacy, utility, or functional improvement associated with the use of this narcotic analgesic in this 71-year-old individual. Without the benefit of any functional improvement, ability to return to work, or a reduction in pain complaints; there is no data presented to suggest any reason to continue such a potent narcotic medication. As such, based on the records reviewed, there is insufficient data presented to support the ongoing use of this medication.

LIDODERM 5% PATCH #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, ,

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 56, 57, 112 of 127.

Decision rationale: Lidoderm (Lidocaine patch 5%) is indicated in a very narrowly focused set of circumstances. There needs to be a noted neuropathic etiology (radiculopathy) and there is no noted trial of a first-line neuropathy medication. As such, based on the medical records reviewed, there is no clinical indication for this preparation.

PROMETHAZINE HCL 25MG #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

Decision rationale: The records reviewed do not indicate any complaints of nausea, with the need for antiemetic preparation. Furthermore, use of opiates have been discontinued, this would be another reason for discontinuing this medication. Therefore, based on a complete lack of medical records to support, this request this is not clinically indicated.

FIORICET 50/300/40MG #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, ,

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines Page(s): 23/127.

Decision rationale: This is an individual who has ongoing complaints of pain and has not demonstrated any efficacy, utility or improvement with multiple medications employed. This is a

barbiturate containing medication and is not supported in the MTUS. Therefore, this is not contraindicated.