

Case Number:	CM14-0009617		
Date Assigned:	02/14/2014	Date of Injury:	01/10/2012
Decision Date:	07/23/2014	UR Denial Date:	12/26/2013
Priority:	Standard	Application Received:	01/24/2014

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 54-year-old male with an injury date of 2012. The mechanism of injury is noted as a crush injury resulting in a fracture of the distal lower extremity. Surgical intervention was required. Subsequent to the surgical intervention there have been ongoing complaints of pain. A diagnosis of reflex sympathetic dystrophy has been noted. Multiple enhanced imaging studies were obtained and there was artifact secondary to the metallic (screws) devices inserted. No specific nonunion or lack of healing has been objectified. There are no electrodiagnostic studies noted supporting the diagnosis of reflex sympathetic dystrophy.

IMR ISSUES, DECISIONS AND RATIONALES

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

SPINAL CORD STIMULATOR TRIAL: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines SPINAL CORD STIMULATOR Page(s): 38/127.

Decision rationale: It is noted that the distal lower extremity injury was surgically treated. Subsequent to the surgical intervention, there have been numerous complaints of pain. There is no electrodiagnostic study objectifying an assessment of reflex sympathetic dystrophy. Multiple

enhanced imaging studies have been completed and the studies were compromised secondary to the metallic devices inserted (screw fixation). As such, there is insufficient information to suggest or objectify the diagnosis of Complex Regional Pain Syndrome (CRPS). As such, there is insufficient data presented to support the need for a spinal cord stimulator or trial at this time based on Chronic Pain Medical Treatment Guidelines. Therefore, the request for a Spinal Cord Stimulator is not medically necessary.

WHEEL CHAIR RAMP HOME EVALUATION: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OTHER MEDICAL TREATMENT GUIDELINE OR MEDICAL EVIDENCE: AS THERE IS NO GUIDELINE APPLICABLE TO THIS REVIEW, CLINICAL JUDGMENT AND STANDARDS OF CARE WERE UTILIZED IN MAKING THE DETERMINATION.

Decision rationale: The mechanism of injury and injury sustained are noted. The literature reflects that a Controlled Ankle Movement (CAM) walker is being used to supplement ambulation. There is no notation of the need for a wheelchair. In that there is no clinical indication for a wheelchair and gait can be accomplished with the CAM walker and crutches, there is no indication for wheelchair and no need to assess for a wheelchair ramp. Such as, the wheel chair ramp home evaluation is not medically necessary.

NORCO 10/325MG QTY 240: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS Page(s): 80.

Decision rationale: This is an individual with ongoing complaints of distal lower extremity pain. A diagnosis of a complex regional pain syndrome has been made. What is also noted in the records reviewed is that there is no objectification of any efficacy, utility, functional improvement or ability to return to work with the use of this opioid medication. Given the noted complications, the California Medical Treatment Utilization Schedule (CA MTUS), and that there is no objectified efficacy or functional improvement, there is no clinical reason to continue opioid medications. As such, this request is not medically necessary.

ANAPROX DS QTY 60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS
Page(s): 21/127.

Decision rationale: This medication is a non-steroidal anti-inflammatory preparation. The imaging studies did not identify any specific inflammatory process. There are ongoing complaints of pain and a possible reflex sympathetic dystrophy (wholly not objectified) but there is no indication of any arthritic or other inflammatory process. Therefore, it is not clear why this anti-inflammatory medication has continued to be prescribed as particular interface with the pain complaints have not abated, there is no increase in functionality, and other analgesic medications have been employed. Accordingly, this request is not clinically indicated based on Chronic Pain Medical Treatment Guidelines and is therefore, not medically necessary.

PRILOSEC 20MG QTY 60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS
Page(s): 88/127.

Decision rationale: This is an individual who has been on long-term narcotic medications, long-term non-steroidal anti-inflammatory medications and this preparation to address any possible gastrointestinal reflux disease. However, the progress note reviewed does not indicate that there is any evidence of gastrointestinal reflux disease, or that there is an untoward effect relative to the non-steroidal medications being prescribed. Given that those medications are not clinically indicated for further use, any possible insult to the gastrointestinal tract has been negated. As such, the request for Prilosec is not clinically indicated based on Chronic Pain Medical Treatment Guidelines and is not medically necessary.

RESTORIL 30MG QTY 30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS
Page(s): 24/127.

Decision rationale: This is a benzodiazepine medication and as outlined in the California Medical Treatment Utilization Schedule (CA MTUS), it is not recommended for long-term use as a secondary to the advanced side effect profile. Furthermore, the progress notes reviewed did not identify any specific sleep hygiene issues. Therefore, there is insufficient clinical evidence presented for you to support this request. Such as, the request for Restoril is not medically necessary.