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| Case Number: | CM14-0011017 | | |
| Date Assigned: | 02/21/2014 | Date of Injury: | 10/20/2004 |
| Decision Date: | 06/25/2014 | UR Denial Date: | 01/02/2014 |
| Priority: | Standard | Application Received: | 01/27/2014 |

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 Family Medicine, and is licensed to practice in Arizona. 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 patient is a 58 year old male with a date of injury on 10/20/2004. Diagnoses include lumbago, reflex sympathetic dystrophy lower limb, rotator cuff syndrome, postlaminectomy syndrome, and lumbosacral neuritis. Subjective complaints are of low back pain, left lower extremity pain, left foot hypersensitivity, and medication was noted to provide symptom relief. Physical exam shows tenderness to palpation at lumbar facets L3-S1 and pain with lumbar extension. Prior treatments have included medications, physical therapy, spinal cord stimulator, and diagnostic studies. Medications include Norco 10/325mg 2 tablets 4 times a day, Restoril before bed, Morphine 60mg ER 3 times a day, Gabapentin, Cymbalta, and Benadryl before bed. Submitted documentation states the patient has greater than 65% pain relief with medications, and functional ability and participation in activities of daily living are improved.

IMR ISSUES, DECISIONS AND RATIONALES

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

BENADRYL 25 MG QUANTITY 30: 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 Official Disability Guidelines (ODG) Pain, Insomnia Treatment.

Decision rationale: Request is for this medication to be used at night for treatment of insomnia. The ODG states that pharmacological agents should only be used after careful evaluation of potential causes of sleep disturbance. The ODG suggests that sedating antihistamines are a class of drug that can be used for insomnia. The ODG states that sedating antihistamines have been suggested for sleep aids (for example, diphenhydramine), and tolerance seems to develop within a few days. The submitted documentation does not show evidence of need or efficacy of this medication. Therefore, the medical necessity of Benadryl is not established.

MORPHINE 60 MG QUANTITY 90: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES Page(s): 74-96.

Decision rationale: CA Chronic Pain Guidelines has specific recommendations for the ongoing management of opioid therapy. Clear evidence should be presented about the degree of analgesia, level of activity of daily living, adverse side effects, or aberrant drug taking behavior. For this patient, clear documentation shows stability on medication, increased functional ability, and no adverse side effects. Furthermore, clear documentation is present of MTUS opioid compliance guidelines, including urine drug screening, risk assessment, and ongoing efficacy of medication. Therefore, the use of this medication is consistent with guidelines and is medically necessary for this patient.

RESTORIL 30 MG QUANTITY30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES BENZODIAZEPINES, , 24 Page(s): 24. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Insomnia Treatment.

Decision rationale: The ODG states that pharmacological agents should only be used after careful evaluation of potential causes of sleep disturbance. Failure of sleep disturbance to resolve in a 7 to 10 day period may indicate a psychiatric and/or medical illness. CA MTUS guidelines do not recommend anxiolytics as first line therapy for stress-related conditions as they can lead to dependence and do not alter stressors or the individual's coping mechanisms. Benzodiazepines in particular are not recommended for long-term use because long-term efficacy is unproven. Most guidelines limit use to 4 weeks, due to dependence and tolerance that can occur within weeks. The medical provider indicates the patient had complaints of pain-related insomnia, but there is no documentation of failed trials of guideline supported treatment, such as Lunesta. Therefore, the medical necessity for continued use of Restoril is not established.

NORCO 10/325 MG QUANTITY 240: Overturned

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

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