

<b>Case Number:</b>	CM14-0011122		
<b>Date Assigned:</b>	02/21/2014	<b>Date of Injury:</b>	06/10/2001
<b>Decision Date:</b>	10/20/2014	<b>UR Denial Date:</b>	01/14/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/28/2014

### 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 Internal Medicine 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 47 year old female who has been diagnosed with a traumatic brain syndrome. The sleep studies completed on 03/20/12 indicate the injured worker having mild obstructive events throughout the study. Findings were identified as being severe when in REM sleep. The injured worker was recommended for treatment regarding the sleep apnea. The agreed medical exam dated 08/23/13 indicates the injured worker having findings consistent with cardiac arrhythmias as well as hypertension. The clinical note dated 10/01/13 indicates the injured worker having whole body complaints. It should be pointed out that much of the clinical documentation is handwritten and very difficult to read. The utilization review dated 07/31/13 resulted in a partial certification for Oxycodone in order to provide the injured worker with a safe tapering and weaning.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**ACUPUNCTURE SESSIONS QTY: 6.00: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**Decision rationale:** The documentation indicates the injured worker having a long history of a traumatic brain syndrome injury. No information was submitted regarding the injured worker's previous treatments to include conservative therapies as well as acupuncture. Additionally, no information was submitted regarding the injured worker's functional deficits likely to benefit from the use of acupuncture. Given these findings, the request is not indicated as medically necessary per MTUS guidelines.

**NUTRITIONIST CONSULT EVALUATION AND TREATMENT QTY: 1.00:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Independent Medical Examination and Consultation (ACOEM Practice Guidelines), Chapter 7

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Independent Medical Examination and Consultation, American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 7, page 503.

**Decision rationale:** No information was submitted regarding the injured worker's nutritional status. It is unclear how the injured worker's nutritional status is related to the current brain syndrome injury. Therefore, this request is not medically necessary per the cited guidelines.

**ELECTRIC SCOOTER QTY 1.00:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines POWER MOBILITY DEVICES (PMDS) Page(s): 99.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg Chapter, Power mobility devices (PMDs)

**Decision rationale:** An electric scooter is indicated for injured workers with significant functional deficits and an inability to propel a manual wheelchair. No information was submitted regarding the injured worker's significant functional deficits. Additionally, no information was submitted regarding the injured worker's previous trial of a manual wheelchair. Given these factors, this request is not indicated as medically necessary per ODG.

**SOMA 350MG QTY: 650.00:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines CARISOPRODOL Page(s): 29.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20, Carisoprodol Page(s): 65.

**Decision rationale:** As noted on page 65 of the Chronic Pain Medical Treatment Guidelines, Soma is not recommended for long-term use. This medication is FDA-approved for symptomatic relief of discomfort associated with acute pain in musculoskeletal conditions as an adjunct to rest and physical therapy. The documentation indicates that the injured worker is being prescribed the medication for chronic pain and long-term care exceeding the recommended treatment window. Medical necessity has not been established.

**OXYCONTIN 80 MG QTY: 60.00:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20, Opioids, criteria for use Page(s): 77.

**Decision rationale:** As noted on page 77 of the Chronic Pain Medical Treatment Guidelines, patients must demonstrate functional improvement in addition to appropriate documentation of ongoing pain relief to warrant the continued use of narcotic medications. There is no clear documentation regarding the functional benefits or any substantial functional improvement obtained with the continued use of narcotic medications. As the clinical documentation provided for review does not support an appropriate evaluation for the continued use of narcotics as well as establish the efficacy of narcotics, the medical necessity of Oxycotin 80 mg Qty: 60.00 cannot be established at this time.

**OXYCODONE 20MG QTY: 180.00:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 80.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20, Opioids, criteria for use Page(s): 77.

**Decision rationale:** As noted on page 77 of the Chronic Pain Medical Treatment Guidelines, patients must demonstrate functional improvement in addition to appropriate documentation of ongoing pain relief to warrant the continued use of narcotic medications. In addition, the documentation indicated the injured worker had weaned from the oxycodone negating the request. As such, the medical necessity of Oxycodone 20mg Qty: 180.00 cannot be established at this time.