

Case Number:	CM14-0011617		
Date Assigned:	06/11/2014	Date of Injury:	10/18/2004
Decision Date:	07/22/2014	UR Denial Date:	01/22/2014
Priority:	Standard	Application Received:	01/29/2014

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 & 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 38-year-old male who reported an injury on 10/18/2004 after a large cement beam measured at 9 feet by 9 feet fell on the injured worker. The injured worker reportedly sustained an injury to his head, neck, and back. The injured worker's treatment history included multiple medications and extensive psychiatric support. The patient was evaluated on 11/19/2013. It was documented that the patient was extremely withdrawn and could not effectively engage as a historian. Physical findings included a slow, broad-based antalgic gait. The patient's diagnoses included severe cognitive impairment, brain injury with neurological sequelae, and mixed depression and anxiety disorders secondary to injury. A refill of medications to include methadone, OxyContin, Klonopin, Topamax, and Ambien was made.

IMR ISSUES, DECISIONS AND RATIONALES

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

METHADONE 10MG #300: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS, ON-GOING MANAGEMENT Page(s): 78.

Decision rationale: The requested methadone 10 mg #300 is not medically necessary or appropriate. The clinical documentation submitted for review does indicate that the patient has been on this medication since at least 05/2013. The California Medical Treatment Utilization Schedule recommends the continued use of opioids in the management of chronic pain be supported by documented functional benefit, a quantitative assessment of pain relief, evidence that the injured worker is monitored for aberrant behavior, and managed side effects. The clinical documentation submitted for review failed to provide any evidence of efficacy of this medication. There is no documentation of functional benefit or pain relief. Additionally, the clinical documentation does not provide any evidence that the patient is monitored for aberrant behavior. Furthermore, the request as it is submitted 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 methadone 10 mg #300 is not medically necessary or appropriate.

OXYCONTIN 30MG: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS, ON-GOING MANAGEMENT Page(s): 78.

Decision rationale: The requested OxyContin 30 mg is not medically necessary or appropriate. The clinical documentation submitted for review does indicate that the patient has been on this medication since at least 05/2013. The California Medical Treatment Utilization Schedule recommends the continued use of opioids in the management of chronic pain be supported by documented functional benefit, a quantitative assessment of pain relief, evidence that the injured worker is monitored for aberrant behavior, and managed side effects. The clinical documentation submitted for review failed to provide any evidence of efficacy of this medication. There is no documentation of functional benefit or pain relief. Additionally, the clinical documentation does not provide any evidence that the patient is monitored for aberrant behavior. Furthermore, the request as it is submitted 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 OxyContin 30 mg is not medically necessary or appropriate.

KLONOPIN 1MG: Upheld

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

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

Decision rationale: The requested Klonopin 1 mg is not medically necessary or appropriate. The clinical documentation submitted for review does indicate that the injured worker has been on this medication since at least 05/2013. The California Medical Treatment Utilization Schedule does not recommend the longterm use of benzodiazepines as there is a high risk for

physiological and psychological dependence. The clinical documentation does not provide any exceptional factors to support extending treatment beyond guideline recommendations. Furthermore, the request as it is submitted does not provide a quantity or frequency of treatment. In the absence of this information the appropriateness of the request itself cannot be determined. As such, the requested Klonopin 1 mg is not medically necessary or appropriate.

TOPAMAX 200 MG: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepileptic Drugs Page(s): 16.

Decision rationale: The requested Topamax 200 mg is not medically necessary or appropriate. The clinical documentation submitted for review does indicate that the patient has been on this medication since at least 05/2013. The California Medical Treatment Utilization Schedule does recommend anticonvulsants as first-line medications in the management of chronic pain. However, the California Medical Treatment Utilization Schedule recommends any medication used in the management of chronic pain be supported by documented functional benefit and evidence of pain relief. The clinical documentation fails to provide any evidence of functional improvement or pain relief resulting from the use of this medication. Furthermore, the request as it is submitted does not specifically identify a frequency of treatment. In the absence of this information the appropriateness of the request itself cannot be determined. As such, the requested Topamax 200 mg is not medically necessary or appropriate.

TOPAMAX 50MG: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepileptic Drugs Page(s): 16.

Decision rationale: The requested Topamax 500 mg is not medically necessary or appropriate. The clinical documentation submitted for review does indicate that the patient has been on this medication since at least 05/2013. The California Medical Treatment Utilization Schedule does recommend anticonvulsants as first-line medications in the management of chronic pain. However, the California Medical Treatment Utilization Schedule recommends any medication used in the management of chronic pain be supported by documented functional benefit and evidence of pain relief. The clinical documentation fails to provide any evidence of functional improvement or pain relief resulting from the use of this medication. Furthermore, the request as it is submitted does not specifically identify a frequency of treatment. In the absence of this information the appropriateness of the request itself cannot be determined. As such, the requested Topamax 500 mg is not medically necessary or appropriate.

AMBIEN 10MG: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

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: California Medical Treatment Utilization Schedule does not address this request. The clinical documentation submitted for review does indicate that the patient has been on this medication since at least 05/2013. The Official Disability Guidelines do not recommend the use of this medication for an extended duration of time. Additionally, the efficacy of this medication is not supported by an adequate assessment of the injured worker's sleep hygiene. Furthermore, the request as it is submitted does not provide a quantity or frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Ambien 10 mg is not medically necessary or appropriate.