

Case Number:	CM14-0021483		
Date Assigned:	06/16/2014	Date of Injury:	03/27/2007
Decision Date:	07/16/2014	UR Denial Date:	01/21/2014
Priority:	Standard	Application Received:	02/20/2014

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 and Rehabilitation, has a subspecialty in Pain Medicine 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 53 year old female who sustained an injury on 03/27/07. No specific mechanism of injury was noted. Noted in the records from the injured worker's pain management physician were complaints of chronic pain in the low back and hips. The injured worker's pain scores were rated 6/10 on the VAS. Medications prescribed to the injured worker included Promethazine 25mg on a daily basis, Aciphex 20mg daily, Ativan 1mg daily, Oxycontin 30mg ER twice daily, Percocet 10/325mg once daily, and Savella 100mg twice daily. With medications the injured worker did report an increased ability to perform normal activities of daily living. There was no indication of any substantial medication side effects. There were samples taken for urine drug screen analysis; however, no toxicology results were available for review. No indication of medication diversion, hoarding, or impairment was identified. The clinical report on 12/13/13 noted continuing functional improvement and the ability to work full time with the use of pain medications. Pain was reduced to at least 4/10 on the VAS with medications. On physical examination, the injured worker did demonstrate tenderness to palpation in the lower lumbar spine with limited range of motion. There was also tenderness present in the posterior cervical region with some limited range of motion. The requested CBC, chem profile, Aciphex 20mg, quantity 30, Ativan 1mg, quantity 60, and Percocet 10/325mg, quantity 15 was denied by utilization review on 01/21/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

COMPLETE BLOOD COUNT: 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: Current Medical Treatment and Diagnosis.

Decision rationale: In regards to the request for a CBC, the clinical documentation provided for review did not indicate the rationale for this type of test. There was no indication of any suspected infection or substantial side effects from medications to support the use of a CBC. Given the unclear rationale for the use of this laboratory test, this reviewer would not have recommended the request as medically necessary.

CHEMISTRY PROFILE: 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: Current Medical Diagnosis and Treatment, 2012.

Decision rationale: In regards to the request for a chemistry profile, the clinical documentation provided for review did not indicate the rationale for this type of test. There was no indication of any suspected infection or substantial side effects from medications to support the use of a chemistry profile. Given the unclear rationale for the use of this laboratory test, this reviewer would not have recommended the request as medically necessary.

ACIPHEX 20MG #30: Upheld

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

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, proton pump inhibitors.

Decision rationale: In regards to the use of Aciphex 20mg quantity 30, this reviewer would not have recommended this medication as medically necessary based on the clinical documentation provided for review and current evidence based guideline recommendations. The clinical records provided for review did not discuss any side effects from oral medication usage including gastritis or acid reflux. There was no other documentation provided to support a diagnosis of gastroesophageal reflux disease. Given the lack of any clinical indication for the use of a proton pump inhibitor this reviewer would not have recommended this request as medically necessary.

ATIVAN 1MG #60: 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: In regards to the use of Ativan 1mg quantity 60, this reviewer would not have recommended this medication as medically necessary based on the clinical documentation provided for review and current evidence based guideline recommendations. The chronic use of benzodiazepines is not recommended by current evidence based guidelines as there is no evidence in the clinical literature to support the efficacy of their extended use. The current clinical literature recommends short term use of benzodiazepines only due to the high risks for dependency and abuse for this class of medication. The clinical documentation provided for review does not specifically demonstrate any substantial functional improvement with the use of this medication that would support its ongoing use. As such, this reviewer would not have recommended this request as medically necessary.

PERCOCET 10/325MG #15: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for Use Page(s): 88-89.

Decision rationale: The request for Percocet 10/325mg, quantity 15 would be supported as medically necessary based on review of the clinical documentation submitted as well as current evidence based guidelines. The original request was for a quantity of 15. This quantity of 15 was previously recommended for certification. It is unclear why this quantity of medication was denied. The injured worker did report significant benefit with the continuing use of Percocet and there was no evidence of any non-compliance, diversion, or abuse of this medication. Given that the injured worker was able to work full time with the use of Percocet for pain management, this reviewer would have recommended this request as medically necessary.