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| Case Number: | CM14-0023605 | | |
| Date Assigned: | 06/11/2014 | Date of Injury: | 07/22/1997 |
| Decision Date: | 07/15/2014 | UR Denial Date: | 01/20/2014 |
| Priority: | Standard | Application Received: | 02/25/2014 |

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 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 66-year-old male who reported an injury on 07/22/1997. The mechanism of injury was not provided within the submitted medical records. The clinical note dated 12/12/2013 was note to reveal the injured worker rated his pain as "pretty well" with medications listed as MS Contin 130 mg every 8 hours and Dilaudid 8 mg twice a day as needed. It is further noted that the injured worker continued the use of Ativan on a twice a day basis. The injured worker rated his pain in the neck, back, shoulder, hip, and wrist pain ranging from 3/10 to 7/10 and was noted that overall he was able to perform all basic activities of daily living and assist the wife with most household chores when necessary. The physical exam revealed that the injured worker had a slowed gait and was guarded, but was stable with assistance. The listed diagnoses include postlaminectomy syndrome of the lumbar and cervical regions, adjustment reaction with mixed emotions, and post-traumatic stress disorder. Within the clinical note dated 08/22/2013, it should be noted that there was a phone consultation that produced a change in the treatment plan of decreasing the quantity of Cialis to 4 times a month. The request for authorization was not provided within these medical records.

IMR ISSUES, DECISIONS AND RATIONALES

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

CIALIS 10MG: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Mosby's Drug Consult.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Daily Med Website.

Decision rationale: The request for Cialis 10 mg is not medically necessary. The indicated usage of Cialis is for erectile dysfunction, signs and symptoms of benign prostatic hyperplasia, and erectile dysfunction with signs and symptoms of BPH. Within the submitted medical records, there was no indication that the injured worker had erectile dysfunction and along with a documented decrease in usage, there was no indication that the injured worker had documented results as indicated from the medication. Without documentation to show that the injured worker had an indicated diagnosis to utilize the medication and further documentation to show the efficacy of the medication for the injured worker, the request cannot be supported at this time. As such, the request is not medically necessary.

ZOLPIDEM 12.5MG: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG-TWC Pain Procedure Summary, Zolpidem.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain, Zolpidem (Ambien®).

Decision rationale: The request for Zolpidem 12.5 mg is not medically necessary. The Official Disability Guidelines recommend Zolpidem as a short acting non-benzodiazepine hypnotic, which is approved for short-term (usually 2 to 6 weeks) treatment of insomnia. Proper sleep hygiene is critical to the individual with chronic pain and often is hard to obtain. Various medications may provide short-term benefit. While sleeping pills, so called minor tranquilizers and anti-anxiety agents are commonly prescribed in chronic pain, pain specialists rarely, if ever, recommend them for long-term use. They could be habit forming, and they may impair function and memory more than opioid pain relievers. Given the injured worker has a documented utilization of Zolpidem for a prolonged period of time and there was no documentation of efficacy of the medication, the request is not supported at this time by the guidelines. Lastly, there was no documentation of the injured worker sustaining sleep disruptions. As such, the request is not medically necessary.

THERMACARE: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173-174.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298.

Decision rationale: The request for Thermacare is medically necessary. The California MTUS/ACOEM Guidelines suggest physical methods for initial care of low back pain includes at home local applications of cold in the first few days of acute complaints; thereafter, applications of heat or cold. To find additional support, the Official Disability Guidelines recommend heat therapy, more specifically, continuous low level heat wrap therapy to be effective for treating low back pain. The guidelines further state that combining continuous low level heat wrap therapy with exercise during the treatment of acute low back pain significantly improves functional outcomes. Given the injured worker has complaints of low back pain that have been ongoing and the guidelines support the indicated utilization of Thermacare for low back pain in this situation, the request is supported at this time by the guidelines. As such, the request is medically necessary.

LORAZEPAM 1MG: Upheld

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

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

Decision rationale: The request for Lorazepam 1 mg is not medically necessary. The California MTUS Guidelines do not recommend benzodiazepines for long-term use because long-term efficacy is unproven and there is a risk of dependence. Additionally, most guidelines limit the utilization of benzodiazepines to 4 weeks. The injured worker has documented prolonged usage of this medication beyond the guidelines recommended 4 weeks. Without further documentation that shows extenuating circumstances that would justify utilization of this medication outside of the guidelines recommend utilization period, the request cannot be supported by the guidelines at this time. As such, the request is not medically necessary.