

Case Number:	CM14-0026186		
Date Assigned:	07/02/2014	Date of Injury:	10/12/2005
Decision Date:	08/13/2014	UR Denial Date:	01/28/2014
Priority:	Standard	Application Received:	02/28/2014

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 Physical Medicine & Rehabilitation and is licensed to practice in Texas and Oklahoma. 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 54-year-old female who reported an injury on 10/12/2005. The mechanism of injury was noted to be physical assault. The injured worker's prior treatments were noted to be acupuncture and physical therapy. Diagnoses were included neck pain, myalgia and myositis, as well as reflex sympathetic dystrophy to the upper extremity. The injured worker had a physical evaluation on 06/20/2014. She presented with continued back pain. Using the numeric pain intensity scale of 0 to 10, she reported her pain without medication at a 9 and with medication at a 7. The physical exam findings were noted to be normal with the exception of the injured worker's inability to raise her right arm to 150 degrees. The treatment plan included medication refills. The provider's rationale for the requested medications was partially provided within the clinical evaluation on 06/20/2014. A request for authorization for medical treatment for the 3 medications requested was not provided within the documentation.

IMR ISSUES, DECISIONS AND RATIONALES

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

VALIUM 10 MG QTY 10: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines BENZODIAZEPINES Page(s): 94.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ANTISPASTICITY/ANTISPASMODIC DRUGS,Benzodiazapines Page(s): page(s) 66;page(s) 24.

Decision rationale: The California MTUS Chronic Pain Medical Treatment Guidelines do not recommend benzodiazepines due to the rapid development of tolerance and dependence. Benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. The range of action includes sedative/hypnotic, anxiolytic, anticonvulsants, and muscle relaxant. Chronic benzodiazepines are the treatment of choice in very few conditions. Tolerance to hypnotic effects develops rapidly. Tolerance to anxiolytic effects occurs within months and long-term use may actually increase anxiety. Tolerance to anticonvulsants and muscle relaxant effects occurs within weeks. The clinical evaluation submitted with this review dated 06/20/2014 does not provide Valium on the medication list or within the treatment plan. In addition, the request for Valium fails to provide a frequency. Therefore, the request for Valium 10 mg quantity 10 is not medically necessary and appropriate.

CLONIDINE HCL 0.1 MG QTY 240: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Clonidine, Intrathecal Page(s): 34.

Decision rationale: The California MTUS Chronic Pain Medical Treatment Guidelines only recommend clonidine after a short-term trial indicates pain relief in patients' refractory to opioid monotherapy or opioids with local anesthetic. There is little evidence that this medication provides long-term pain relief (when used in combination with opioids approximately 90% of patients had less than 24 months of pain relief) and no studies have investigated the neuromuscular, vascular, or cardiovascular physiologic changes that can occur over a long period of administration. The documentation provided for review indicates a drug list of current medications and medications that have been added, continued or stopped. There is not a clonidine within this list. It is not indicated that the injured worker has completed a short-term trial. There is not an adequate pain assessment with the review. In addition, the request for clonidine fails to provide a frequency. Therefore, the request for clonidine HCL 0.1 mg quantity 240 is not medically necessary and appropriate.

ESIG 50/325/40 MG QTY 120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines BARBITURATE-CONTAINING ANALGESIC AGENTS Page(s): 23.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Barbiturate-containing analgesic agents Page(s): 23.

Decision rationale: The California MTUS Chronic Pain Medical Treatment Guidelines do not recommend barbiturate containing analgesic agents for chronic pain. The potential for drug dependence is high and no evidence exists to show a clinically important enhancement of analgesic efficacy of barbiturate containing analgesics due to the barbiturate constituency. There is a risk of medication overuse as well as rebound headache. According to the clinical evaluation on 06/20/2014, the injured worker was prescribed this medication to take for headache. It is not documented that conservative therapies have failed to provide headache relief for the injured worker. The guidelines do not recommend barbiturate containing analgesic agents. In addition, the request fails to provide a frequency. Therefore, the request for ESIG 50/325/40 mg quantity 120 is not medically necessary and appropriate.