

Case Number:	CM14-0026650		
Date Assigned:	03/05/2014	Date of Injury:	10/28/2009
Decision Date:	04/29/2014	UR Denial Date:	01/31/2014
Priority:	Standard	Application Received:	03/03/2014

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, has a subspecialty in Interventional Spine 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:

This patient is a 57-year-old female with date of injury 10/28/2009. Per treating physicians report 11/07/2013, the patient presents with right forearm and thumb pain at an intensity of 4/10. Pain radiates into the right hand associated with neck pain and numbness. Medications are helping. Pain level has increased since last visit. Botox injection helped from 2 weeks ago. Current listed medications were Lunesta, naproxen, Percocet 1 at nighttime, Restoril and Valium. Listed diagnoses were tenosynovitis of the hand and wrist, pain in joint and forearm. Under treatment plan, indicates that the patient's ADL was impaired, improving and no recent acute problem.

IMR ISSUES, DECISIONS AND RATIONALES

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

DIAZEPAM (VALIUM) 10MG QTY: 30.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines BENZODIAEPINES Page(s): 24.

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

Decision rationale: The Expert Reviewer's decision rationale: This patient presents with chronic neck and upper extremity pain. There is a request for Valium 10 mg #10. Review of the reports

show that patient has been prescribed Valium on a long term basis. MTUS Guidelines do not support use of benzodiazepine for long term basis. Only short term use of this medication is recommended. In this case, review of the reports show that the patient had benzodiazepine in the urine tested on 08/19/2013 with treating physician's report 11/07/2013 listing Valium. This would indicate that the patient has been on this for at least several months. Given the long term use of Valium which is not recommended by MTUS Guidelines, recommendation is for denial

PERCOCET 10-325MG QTY: 30.00: 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 LONG TERM OPIOID Page(s): 88-89.

Decision rationale: The Expert Reviewer's decision rationale: Review of the reports show that this patient has been on Percocet for quite some time but none of the reports provided by [REDACTED] from 06/17/2013 to 11/07/2013 list any other medications. None of the reports discuss efficacy of this medication in terms of pain reduction and improvement in function. [REDACTED] does discuss and list these medications on 11/07/2013 report as well as 12/10/2013 report. He only indicates "she states that medications are helping" but this sentence is followed by "pain level has increased since last visit." Treating physician also documents impaired ADL. There is no mention of efficacy from use of Percocet. MTUS Guidelines require certain documentations for chronic opiate use. Pain assessment and function is required compared to baseline, use of numeric scale to denote function or use of validated instrument. Furthermore, 4 A's including analgesia, ADLs, adverse effects, aberrant behavior are required for documentation. In this patient, there is no documentation of analgesia, no documentation of significant change in activities of daily living in any of the reports reviewed. Recommendation is for denial.

RESTORIL 7.5MG QTY: 30.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines BENZODIAEPINES Page(s): 24.

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

Decision rationale: The Expert Reviewer's decision rationale: This patient presents with chronic neck and upper extremity pain. There is request for Restoril. MTUS Guidelines do not support use of benzodiazepines for long term use. ODG Guidelines do not support benzodiazepine for long term use to manage insomnia either. In this case, review of the reports show that patient has been prescribed this medication for at least several months. There are no documentations as to how this medication is effective. Most importantly, the guidelines do not recommend long term use of this medication and recommendation is for denial.

TRAZADONE 50MG QTY: 30.00: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ANTIDEPRESSANTS FOR CHRONIC PAIN Page(s): 13.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) STRESS MENTAL CHAPTER

Decision rationale: The Expert Reviewer's decision rationale: This patient presents with chronic neck and upper extremity symptoms. There is a request for trazodone. Review of the reports show that this patient suffers from chronic pain in the neck and upper extremity. The 12/10/2013 reports patient being seen by mental health professional for CBT to start antidepressants. It is apparent the patient has concurrent depression along with chronic pain. ODG Guidelines support the use of trazodone for insomnia in patients that have concurrent depression disorder. Recommendation is for authorization.