

Case Number:	CM14-0027354		
Date Assigned:	03/07/2014	Date of Injury:	04/16/2008
Decision Date:	06/09/2014	UR Denial Date:	02/21/2014
Priority:	Standard	Application Received:	03/05/2014

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 Internal Medicine and is licensed to practice in North Carolina, Colorado, California and Kentucky. 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 patient is a 43 year old male injured on 04/16/08 due to an undisclosed mechanism of injury. Neither the specific injury sustained nor the initial treatments rendered were addressed in the clinical documentation submitted for review. It was noted in the clinical documentation that the patient received multiple epidural steroid injections, facet blocks, medications, aqua therapy, and psychotherapy without improvement in pain. The patient was also receiving in home assistance on a daily basis. The most recent clinical documentation indicated the patient rated his pain at 8-9/10 without medications and 5/10 with medications. The clinical documentation indicated the patient continued medications to allow participation in activities of daily living; however, this required daily home health assistance as the patient was wheelchair bound on most days. The most recent physical examination reported atrophy of bilateral legs, muscle strength 4/5 to bilateral lower extremities, and lumbosacral pain radiating to bilateral lower extremities. Current medications included OxyContin 30mg POBID, Percocet 10/325mg Q6 hours, Fioricet QHS PRN, and Restoril 30mg QHS.

IMR ISSUES, DECISIONS AND RATIONALES

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

PRESCRIPTION OF RESTORIL 30MG: 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: As noted on page 24 of the Chronic Pain Medical Treatment Guidelines, 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. Studies have shown that tolerance to hypnotic effects develops rapidly and tolerance to anxiolytic effects occurs within months. It has been found that long-term use may actually increase anxiety. As such the request for Restoril 30mg cannot be recommended as medically necessary at this time.

PRESCRIPTION OF FIORICET #30: Upheld

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): 77.

Decision rationale: As noted on page 77 of the Chronic Pain Medical Treatment Guidelines, patients must demonstrate functional improvement in addition to appropriate documentation of ongoing pain relief to warrant the continued use of narcotic medications. There is no clear documentation regarding the functional benefits or any substantial functional improvement obtained with the continued use of narcotic medications. The patient continues to require home health assistance and is partially wheelchair bound. As the clinical documentation provided for review does not support an appropriate evaluation for the continued use of narcotics as well as establish the efficacy of narcotics, the medical necessity of Fioricet #30 cannot be established at this time.

PRESCRIPTION OF PERCOCET 1/325MG, #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria For Use Page(s): 77.

Decision rationale: As noted on page 77 of the Chronic Pain Medical Treatment Guidelines, patients must demonstrate functional improvement in addition to appropriate documentation of ongoing pain relief to warrant the continued use of narcotic medications. There is no clear documentation regarding the functional benefits or any substantial functional improvement obtained with the continued use of narcotic medications. The patient continues to require home health assistance and is partially wheelchair bound. As the clinical documentation provided for review does not support an appropriate evaluation for the continued use of narcotics as well as establish the efficacy of narcotics, the medical necessity of Percocet 1/325mg, #120 cannot be established at this time.