

Case Number:	CM14-0029219		
Date Assigned:	07/11/2014	Date of Injury:	06/16/2008
Decision Date:	08/19/2014	UR Denial Date:	02/20/2014
Priority:	Standard	Application Received:	03/07/2014

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 Illinois. 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 27-year-old female who reported an injury on 06/16/2008. The mechanism of injury was not provided for review. The injured worker ultimately developed reflex sympathetic dystrophy, chronic pain syndrome, and chronic pain related to insomnia. The injured worker was evaluated on 09/19/2013. It was documented that the injured worker had to discontinue the use of Dilaudid and Butrans due to uncontrolled side effects. The injured worker was evaluated on 02/12/2014. It was documented that the injured worker had continued controlled acute flare-ups of pain. Physical findings included a pale appearance and significant distress, with positive weight gain. The injured worker's treatment plan included continuation of medications to include Nucynta, Zofran, and Gabadone. In addition, a functional restoration program was recommended.

IMR ISSUES, DECISIONS AND RATIONALES

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

NESP-R program x 4 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Functional restoration programs (FRPs) Page(s): 49.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Management Program (Functional Restoration Program) Page(s): 30.

Decision rationale: The requested NESP-R program times 4 weeks is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does recommend functional restoration programs for patients who are at risk for delayed recovery due to an inability to manage chronic pain. The clinical documentation submitted for review does support that the patient has pain that is not well-controlled with medication usage and that the patient has significant side effects regarding medication usage. Therefore, a functional restoration program would be appropriate for this patient. However, The California Medical Treatment Utilization Schedule recommends a trial of 2 weeks or 80 hours to establish efficacy and patient compliance. The request exceeds this recommendation. There are no exceptional factors noted to support extending treatment beyond guideline recommendations. As such, the requested NESP-R program times 4 weeks is not medically necessary or appropriate.

Butrans patch 10 mcg/hr: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain and Buprenorphine Page(s): 27.

Decision rationale: The requested Butrans Patch 10 mcg/hour is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends the continued use of medications be based on documented functional benefit and evidence of pain relief. The clinical documentation submitted for review does indicate that the patient has treatment history with this medication. It is documented that the patient did not have well-controlled pain and had significant side effects with this medication. Therefore, re-initiation of this medication would not be indicated. Furthermore the request as it is submitted does not clearly identify a frequency of treatment. In the absence of this information the appropriateness of the request itself cannot be determined. As such, the requested Butrans Patch 10 mcg/hour is not medically necessary or appropriate.

Namenda 5 mg: Upheld

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

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: www.webmd.com.

Decision rationale: The requested Namenda 5 mg is not medically necessary or appropriate. The clinical documentation submitted for review does not indicate that this is part of the patient's medication treatment plan. The California Medical Treatment Utilization Schedule and Official Disability Guidelines do not address this medication. An online resource, WebMed.com, indicates that this medication is primarily used to address mild to moderate confusion related to dementia. The clinical documentation submitted for review does not provide any evidence that

the patient has symptoms that would require treatment from this medication. Additionally, the request as it is submitted does not specifically identify a quantity or frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Namenda 5 mg is not medically necessary or appropriate.