MAXIMUS Federal Services

Case Number:	CM14-0051431		
Date Assigned:	06/23/2014	Date of Injury:	11/19/2005
Decision Date:	07/22/2014	UR Denial Date:	03/15/2014
Priority:	Standard	Application Received:	03/21/2014

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 and 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 60-year-old female with a report date of injury of 11/19/2005. The mechanism of injury was not provided within the clinical notes. The clinical note dated 02/11/2014 reported that the injured worker complained of pain and instability to her bilateral knees. The physical examination of the injured worker's lumbar spine revealed limited range of motion, demonstrating flexion to 15 degrees, extension to 10 degrees, rotation (right) to 20 degrees, rotation (left) to 15 degrees, and right and left tilt to 10 degrees. It was reported that the injured worker had decreased pin sensation in the foot dorsum and posterior lateral calf. The injured worker's diagnoses included cervical disc bulges, C5-6 and C7; upper extremity overuse tendinitis; ganglion cysts, bilateral wrists; thoracic disc bulges; lumbar facet arthropathy; right knee pes bursitis; status post right knee arthroscopy with partial lateral meniscectomy; chondral debridement of the tibia; insomnia; depression; anxiety; and nonindustrial hysterectomy with genital and urinary bleeding. The injured worker's medication listed included Vicodin, omeprazole, and Restone. The provider requested Restone and Vicodin for the treatment of insomnia and pain. The request for authorization was submitted on 03/21/2014. The injured worker's prior treatments were not provided within the clinical information.

IMR ISSUES, DECISIONS AND RATIONALES

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

Restone 30 mg #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Insomnia Treatment, Pharmacologic Treatment.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for chronic pain Page(s): 61. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Mental Illness & Stress, Insomnia treatment.

Decision rationale: The injured worker complained of pain and instability to her bilateral knees. The treating physician's rationale for Restone is for the treatment of insomnia. Restone consist of melatonin/l-tryptophan. Restone is an herbal product. It works by increasing certain substances in the brain. The MTUS Chronic Pain Guidelines recognize herbal medications as a medication choice for the treatment of pain (not all are recommended). The Official Disability Guidelines recommend insomnia treatment that is based on the etiology of injured worker's insomnia. Melatonin is indicated for difficulty with sleep onset; however, total sleep time has not been improved. There is a lack of clinical information provided documenting the efficacy of Restone as evidenced by decreased insomnia and increased sleep hygiene, with significant objective functional improvements. Furthermore, the requesting provider did not specify the utilization frequency of the medication being requested. Given the information provided, there is insufficient evidence to determine appropriateness to warrant the medical necessity. Therefore, the request is not medically necessary and appropriate.

Vicodin 7.5/325 mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Hydrocodone (Vicodin, Lortab); Opioids, criteria for use Page(s): 51;78.

Decision rationale: The treating physician's rationale for Vicodin is for the treatment of pain. The MTUS Chronic Pain Guidelines state hydrocodone is a semi-synthetic opioid which is considered the most potent oral opioid that does not require special documentation for prescribing in some states. The MTUS Chronic Pain Guidelines recognize four domains that have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non-adherent) drug-related behaviors. There is a lack of clinical information provided documenting the efficacy of Vicodin as evidenced by decreased pain and significant objective functional improvements. Moreover, there is a lack of documentation that the injured worker has had urine drug screens to validate proper medication adherence in the submitted paperwork. Furthermore, the requesting provider did not specify the utilization frequency of the medication being requested. Given the information provided, there is insufficient evidence to determine appropriateness to warrant the medical necessity. As such, the request is not medically necessary and appropriate.