

Case Number:	CM14-0079376		
Date Assigned:	07/18/2014	Date of Injury:	01/15/2012
Decision Date:	09/15/2014	UR Denial Date:	04/30/2014
Priority:	Standard	Application Received:	05/29/2014

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 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 47-year-old female who reported an injury on 01/15/2012 due to assisting a loss prevention officer in placing an individual in handcuffs when she was punched in the right side of her face which caused her to fall to the floor. Diagnoses were spinal stenosis in cervical region, pain in soft tissues of limb, unspecified essential hypertension, and insomnia unspecified. Past treatments were acupuncture; aquatic therapy; physical therapy; epidural steroid injections to the cervical spine; right stellate ganglion block at the C7 level; and C4, C5, and C6 dorsal root medial branch radiofrequency ablation. Diagnostic studies included an x-ray of the cervical neck, an MRI of the cervical neck, and a CT scan of the head. There was no surgical history reported. The physical examination on 06/13/2014 revealed complaints of pain that radiated to the right shoulder and right upper arm. The pain was described as a 7/10 on the pain scale. Pain was better at resting. The examination of the cervical spine revealed range of motion was intact with right and left rotation to 90 degrees. Lateral rotation to the right and left was to 45 degrees. Spurling's test was negative bilaterally. Lumbar range of motion was normal with flexion to 90 degrees. Right and left lateralization was normal to 30 degrees. Straight leg raise test was negative bilaterally. Medications were Norco, Gralise, Ativan, Ambien, Abilify, atenolol, Cymbalta, and Zanaflex. The treatment plan was to continue medications as directed. The rationale and request for authorization were not submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ativan 1mg #60: Upheld

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

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

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines do not recommend the use of benzodiazepines as treatment for patients with chronic pain for longer than 3 weeks due to a high risk of psychological and physiological dependency. The clinical documentation submitted for review does provide evidence that the patient has been on this medication for an extended duration of time. Therefore, continued use would not be supported. Also, the request does not indicate a frequency for the medications. Therefore, the request is not medically necessary.

Gralise 1200mg to titrate: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepileptic Drugs Page(s): 16,17.

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines recommend antiepilepsy medications as a first line medication for treatment of neuropathic pain. There should be documentation of an objective decrease in pain of at least 30% to 50% and objective functional improvement. There was no objective decrease in pain reported. The efficacy of this medication was not reported. Also, the request does not indicate a frequency for the medication. Therefore, the request is not medically necessary.