

Case Number:	CM14-0088145		
Date Assigned:	07/23/2014	Date of Injury:	07/01/2011
Decision Date:	08/28/2014	UR Denial Date:	05/19/2014
Priority:	Standard	Application Received:	06/11/2014

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 Pain Medicine and is licensed to practice in Texas and Oklahoma. 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 male who reported an injury on 07/01/2011 after a motor vehicle accident. The injured worker reportedly sustained an injury to his lumbar spine and left upper extremity. The injured worker developed chronic pain that was managed with multiple medications. The injured worker was evaluated on 05/13/2014. It was documented that the injured worker had pain complaints rated at a 7.5/10 with medications, and having increased to an 8.5/10 without medications. It was noted that the injured worker had received authorization for a left cervical stellate ganglion block. Physical findings included left shoulder pain with restricted range of motion and numbness in the forearm. The injured worker's diagnoses included neck and shoulder/arm pain, sensory disturbances, and tinnitus and dizziness. The injured worker's treatment plan included that a request was made for a refill of medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lunesta 3mg #60 for date of service 5/13/14: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Insomnia Treatments.

Decision rationale: The requested Lunesta 3 mg #60 for date of service 05/13/2014 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not address this type of medication. Official Disability Guidelines recommend this medication as a pharmacological intervention for injured workers who have insomnia related to chronic pain. The clinical documentation submitted for review does not provide an adequate assessment of the injured worker's treatment history to support that they need additional treatment. There is no documentation that the injured worker has disturbed sleep patterns that would benefit from this type of medication. Additionally, the request as it is submitted does not clearly identify frequency of treatment. In the absence of this information the appropriateness of the request itself can not be determined. As such, the requested Lunesta 3 mg #60 for date of service 05/13/2014 is not medically necessary or appropriate.

Diamox sequels 500mg #60 for date of service 5/13/14: 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.

Decision rationale: The requested Diamox Sequels 500 mg #60 for date of service 05/13/2014 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not address this medication and Official Disability Guidelines also do not address this medication. An online resource, rxlist.com indicates that this medication is appropriate for injured workers with glaucoma or acute onset of mountain sickness. The clinical documentation submitted for review does not provide any evidence that the injured worker has glaucoma that would require the use of this medication. There is no justification for the need for this medication. Additionally, the request as it is submitted does provide a frequency of treatment. In the absence of this information the appropriateness of the request itself can not be determined. As such, the requested Diamox Sequels 500 mg #60 for date of service 05/13/2014 is not medically necessary or appropriate.

Percocet 10/325mg #130 for date of service 5/13/14: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-Going Management Page(s): page(s) 77.

Decision rationale: The requested Percocet 10/325 mg #130 for date of service 05/13/2014 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends the ongoing use of opioids in the management of chronic pain be supported by a documented functional benefit, a quantitative assessment of pain relief, managed side effects, and evidence that the injured worker is monitored for aberrant behavior. The clinical documentation submitted for review indicates that the injured worker has a reduction in pain from an 8.5/10 to a 7.5/10. This does not support an adequate response to the injured worker's medication schedule. Additionally, there is no documentation of functional benefit or that the injured worker is monitored for aberrant behavior. Therefore, continued use of this medication will not be supported. Furthermore, the request as it is submitted does not provide a frequency of treatment. In the absence of this information the appropriateness of the request itself can not be determined. As such, the requested Percocet 10/325 mg #130 for date of service 05/13/2014 is not medically necessary or appropriate.

Bisacodyl 5mg #60 for date of service 5/13/14: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Initiating Treatment, page(s) 77 Page(s): page(s) 77.

Decision rationale: The requested bisacodyl 5 mg #60 for date of service 05/13/2014 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does recommend the prophylactic treatment of constipation when an injured worker is on chronic opioid therapy. However, the clinical documentation submitted for review does not provide an adequate assessment of the injured worker's gastrointestinal system to support that they are at continued risk for constipation and require this medication. 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 bisacodyl 5 mg #60 with a date of service 05/13/2014 is not medically necessary or appropriate.