

Case Number:	CM15-0202262		
Date Assigned:	10/19/2015	Date of Injury:	08/21/2012
Decision Date:	11/30/2015	UR Denial Date:	09/10/2015
Priority:	Standard	Application Received:	10/14/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: California, Indiana, New York
 Certification(s)/Specialty: Internal Medicine

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 45 year old male who sustained an industrial injury on 08-21-2012. According to the most recent report submitted for review and dated 08-22-2015, the injured worker reported intermittent sharp pain and tingling sensation in his neck. He also reported migraine headaches. Intensity of pain on average was rated 4 on a scale of 1-10. Pain was decreased with rest and medications. His past nonindustrial medical history included asthma, sleep apnea and history of depression. Medications included Losartan. Cranial nerves II through XII were intact except the eye convergence that was related to cranial nerve II. The injured worker had weakness in eye convergence. Deep tendon reflexes were 2 plus in the upper and lower extremities bilaterally. Power was estimated to be 5 out of 5 in the upper and lower extremities bilaterally. Sensory examination of the upper and lower extremities did not reveal any sensory deficit. Babinski sign and Romberg's test was negative. Physical examination of the cervical spine demonstrated tenderness to palpation of the parafacet region of C3 through C6 vertebrae. Range of motion was mildly decreased during right lateral flexion, extension and left side rotation of the cervical spine. The rest of the range of motion was within normal limits. The injured worker was to remain on total temporary disability status. Diagnoses included postconcussion syndrome and cervical spine sprain and strain discogenic pain. Treatment recommendations included "analgesic medications", MRI of the cervical spine, home exercise program and TENS. Medications prescribed were not listed. On 09-10-2015, Utilization Review modified the request for Tylenol #3 #60.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tylenol #3 #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain section, Opioids.

Decision rationale: Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, Tylenol #3, #60 is not medically necessary. Ongoing, chronic opiate use requires an ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects. A detailed pain assessment should accompany ongoing opiate use. Satisfactory response to treatment may be indicated patient's decreased pain, increased level of function or improve quality of life. The lowest possible dose should be prescribed to improve pain and function. Discontinuation of long-term opiates is recommended in patients with no overall improvement in function, continuing pain with evidence of intolerable adverse effects or a decrease in functioning. The guidelines state the treatment for neuropathic pain is often discouraged because of the concern about ineffectiveness. In this case, the injured worker's working diagnoses are post concussion syndrome; and cervical spine sprain strain/discogenic pain. Date of injury is August 21, 2012. Request for authorization is September 8, 2015. The medical record contains 17 pages. Neurology notes prior to the August 24, 2015 progress note did not contain a current list of medications. A supplemental AME dated August 11, 2015 does not document medications. According to an August 24, 2015 new patient evaluation, subjective complaints include migraine headache and neck pain. Objectively, there is tenderness over the facets C3 - C6 with decreased range of motion. The treatment plan indicates the treating provider is going to prescribe analgesics, but does not document the name of the drug, strength of the drug or frequency/instructions for use. The utilization review indicates Tylenol #3 was first prescribed August 24, 2015. The request for authorization contains the name of the analgesic to be prescribed. There is no clinical indication or rationale for Tylenol #3. There is no documentation of prior opiate analgesic drug use. There are no detailed pain assessments or risk assessments. Based on the clinical information in the medical record, peer-reviewed evidence-based guidelines, no documentation of prior opiate use, no detailed pain assessment score risk assessments and no documentation in the new patient evaluation dated August 24, 2015 of the prescribed drug (other than analgesic), Tylenol #3, #60 is not medically necessary.