

<b>Case Number:</b>	CM15-0046089		
<b>Date Assigned:</b>	03/18/2015	<b>Date of Injury:</b>	05/11/2010
<b>Decision Date:</b>	05/11/2015	<b>UR Denial Date:</b>	02/27/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/11/2015

### 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

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & General Preventive 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 46-year-old male who reported injury on 05/11/2010. The mechanism of injury was not provided. Prior surgical history included right shoulder surgery. The mechanism of injury was electrocution. There was a Request for Authorization submitted for review dated 02/18/2015. The documentation of 02/18/2015 revealed the injured worker had a wisp mask that was helping, but his left nostril was closing every night and waking him up, even with Flonase. The injured worker had increased anxiety due to no psychiatric medications. The injured worker's skin grafts were dry, and he had pain because he had no cream. The nasal sprays were not helping. The injured worker complained of shortness of breath, low back pain, and right leg pain; and the right leg was note to go out. The objective findings revealed the injured worker had nasal speech and bilateral thigh and abdomen burns with skin graft that were dry and painful to touch, that had increased since the cream had been stopped. The injured worker had discoloration, distortion, allodynia, hypotia, pseudo motor changes, sensory change, and a osteophytes Nylen-Barany (Dix-Hallpike). The injured worker had decreased range of motion of 100 degrees on the right shoulder. The injured worker had a positive Romberg's, and had decreased dexterity and decreased finger-nose strength. The injured worker's medications included oxycodone APAP 10/325 mg, Percocet 10/325 mg, and Cialis 10 mg #10. The diagnoses included status post severe electrocution with extensive body burns, 05/11/2010; severe obstructive sleep apnea on home CPAP since 03/15/2012; erectile dysfunction; middle ear trauma; post-traumatic hearing loss, traumatic brain injury, right shoulder tear status post surgery

05/20/2014, depression, right lower back pain, and right lower extremity radiculopathy. The treatment plan included transportation to and from all medical appointments, CPAP supplies with wisp mask, home life cycle, ammonium lactate cream 12% 385 grams, fluticasone 50 mg #16, refill Norco 10/325, all certified on 01/21/2014; weight watchers with food supplements for 6 months, follow-up with ENT, psych and psychotherapy, urology evaluation and treatment for erectile dysfunction; oxycodone APAP #60, Fioricet #40, clonazepam 2 mg #60, fluoxetine 40 mg #30, and zolpidem 5 mg #30.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Oxycodone/APAP 10/325mg #60: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 76-80.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic pain, Ongoing Management Page(s): 60 and 78.

**Decision rationale:** The California MTUS Guidelines recommend opiates for the treatment of chronic pain. There should be documentation of objective functional improvement, an objective decrease in pain, and documentation the injured worker is being monitored for aberrant drug behavior and side effects. The clinical documentation submitted for review failed to provide documentation of the above criteria. Additionally, the request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for oxycodone/APAP 1/325 mg #60 is not medically necessary.

**Fioricet #40, with 5 refills: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Barbiturate-Containing Analgesic Agents (BCAs) Page(s): 23.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Barbiturate-containing analgesic agents (BCAs) Page(s): 23.

**Decision rationale:** The California MTUS Guidelines do not recommend barbiturate containing analgesic for chronic pain. The documentation indicated this was one of the injured worker's current medications. The efficacy was not provided. There was a lack of documentation of exceptional factors to warrant non-adherence to guideline recommendations. There was a lack of documentation to support a necessity for 5 refills without re-evaluation. The request as submitted failed to indicate the strength and the frequency for the requested medication. Given the above, the request for Fioricet #40 with 5 refills is not medically necessary.

**Zolpidem 5 mg #30 with 5 refills: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Insomnia Treatment.

**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, Zolpidem.

**Decision rationale:** The Official Disability Guidelines indicate that zolpidem is recommended for the short term treatment of insomnia. The clinical documentation submitted for review indicated the injured worker had utilized the medication previously. The efficacy was not provided. There was a lack of documentation of exceptional factors and documentation for a necessity for 5 refills without re-evaluation. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for zolpidem 5 mg #30 with 5 refills is not medically necessary.

**Follow up with a dermatologist:** Overturned

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

**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, Office Visits.

**Decision rationale:** The Official Disability Guidelines indicate the need for a clinical office visit with a health care provider is individualized based upon a review of the patient's concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The clinical documentation submitted for review indicated the injured worker had extensive bilateral thigh and abdomen burns with skin grafts that were dry and painful to touch. This would support the necessity for a follow-up with a dermatologist. Given the above, the request for follow-up with dermatologist is medically necessary.