

Case Number:	CM15-0051117		
Date Assigned:	03/24/2015	Date of Injury:	05/22/1997
Decision Date:	05/01/2015	UR Denial Date:	02/28/2015
Priority:	Standard	Application Received:	03/18/2015

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: Massachusetts

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 51-year-old male, with a reported date of injury of 05/22/1997. The diagnoses include degenerative disc disease, lumbar lumbosacral degeneration, postlaminectomy cervical syndrome, postlaminectomy lumbar syndrome, cervical radiculopathy, lumbar radiculopathy, chronic neck pain, status post stroke, and seizures. Treatments to date have included oral medications, topical medications, cervical fusion, an MRI of the cervical spine, an x-ray of the lumbar spine, an x-ray of the thoracic spine, computerized tomography (CT) scan of the cervical spine, and intrathecal (IT) pump. The visit note dated 02/17/2015 indicates that the injured worker complained of low back pain with radiation down the right leg. The physical examination showed a slow gait, loss of normal cervical lordosis; restricted cervical range of motion; tenderness and tight muscle band on both paravertebral cervical muscles; tenderness, spasm, and tight muscle band on both paravertebral thoracic muscles; restricted lumbar range of motion; tenderness and tight muscle band of the bilateral paravertebral lumbar muscles; tenderness of the L4 and L4 spinous process; and tenderness over the posterior iliac spine on both sides of the sacroiliac spine. The treating physician requested Seroquel and Fentanyl.

IMR ISSUES, DECISIONS AND RATIONALES

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

Seroquel 400 mg Qty 34: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Mental Illness & Stress.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) (1) Mental Illness & Stress, Insomnia (2) Mental Illness & Stress, Insomnia treatment.

Decision rationale: The claimant has a remote history of a work-related injury and continues to be treated for failed back surgery syndrome. Treatments include an intrathecal pump. When seen by the treating provider he had pain unchanged with the infused medications. No further pump medication increase was planned. Pain was rated from 7-9/10. The treatment of insomnia should be based on the etiology and pharmacological agents should only be used after careful evaluation of potential causes of sleep disturbance. In this case, the nature of the claimant's sleep disorder is not provided. There is no assessment of factors such as sleep onset, maintenance, quality, or next-day functioning. Whether the claimant has primary or secondary insomnia has not been determined. Therefore, Seroquel was not medically necessary.

Fentanyl 10 mg/ml and Bupivacaine 150 mcg/ml - Qty 40 ml: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids and Intrathecal drug delivery systems, medications Page(s): 74-95, 54-55.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines (1) Opioids, criteria for use, p76-80 (2) Opioids, dosing, p86 Page(s): 76-80, 86.

Decision rationale: The claimant has a remote history of a work-related injury and continues to be treated for failed back surgery syndrome. Treatments include an intrathecal pump. When seen by the treating provider he had pain unchanged with the infused medications. No further pump medication increase was planned. Pain was rated from 7-9/10. In this case, there is no evidence of progress towards a decreased reliance on medical care or return to work plan. There is poor pain control, and the claimant appears to be becoming more dependent in terms of medical care usage. The claimant meets criteria for discontinuing opioid medication and therefore continued prescribing of Fentanyl and Bupivacaine without plan for tapering and discontinuance was not medically necessary.