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| Case Number: | CM15-0057893 | | |
| Date Assigned: | 04/02/2015 | Date of Injury: | 10/19/2000 |
| Decision Date: | 06/11/2015 | UR Denial Date: | 03/16/2015 |
| Priority: | Standard | Application Received: | 03/26/2015 |

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, Arizona

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 10/19/2000. The mechanism of injury was not specifically stated. The current diagnoses include lumbago, pain in a joint of the shoulder region, unspecified disorders of the bursa and tendons in the shoulder region, displacement of the cervical interbody disc, degeneration of cervical intervertebral disc, cervicalgia, cervical postlaminectomy syndrome, and brachial neuritis or radiculitis. The injured worker presented on 03/10/2015 for a follow-up evaluation with complaints of chronic severe neck pain as well as lower extremity pain. The injured worker reported 10/10 pain without medication and 8/10 pain with medication. The medication regimen allows for an increased mobility and tolerance of activities of daily living. The current medication regimen includes OxyContin 40 mg, Norco 10/325 mg, Restoril 30 mg and trazodone HCL 100 mg. The injured worker was status post cervical spinal fusion and left shoulder surgery x3. Upon examination, there was bilateral cervical paraspinal muscle spasm, normal upper extremity strength, no evidence of a sensory loss, and 2+ deep tendon reflexes. Treatment recommendations at that time included continuation of the current medication regimen. A Request for Authorization form was submitted on 03/10/2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325mh #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

Decision rationale: California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the injured worker has failed a trial of nonopioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. In this case, it is noted that the injured worker has continuously utilized the above medication since at least 10/2014. The injured worker continues to report constant severe neck pain rated 8/10 with the current medication regimen. There is no documentation of objective functional improvement. There is also no frequency listed in the request. Given the above, the request is not medically necessary.

Oxycontin 40mg #105: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

Decision rationale: California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the injured worker has failed a trial of nonopioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. In this case, it is noted that the injured worker has continuously utilized the above medication since at least 10/2014. The injured worker continues to report constant severe neck pain rated 8/10 with the current medication regimen. There is no documentation of objective functional improvement. There is also no frequency listed in the request. Given the above, the request is not medically necessary.

Restoril 30mg #30 with 1 refill: Upheld

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

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

Decision rationale: California MTUS Guidelines do not recommend benzodiazepines for long term use, because long term efficacy is unproven and there is a risk of dependence. The injured worker does not maintain a diagnosis of anxiety disorder. The medical necessity for the requested medication has not been established in this case. The request for Restoril 30 mg #30

with 1 refill would not be supported as the California MTUS Guidelines do not recommend long term use of benzodiazepines. There is also no frequency listed in the request. Given the above, the request is not medically necessary.

Physical Therapy 12 sessions, left shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98,99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99.

Decision rationale: California MTUS Guidelines state active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. In this case, there was no documentation of a comprehensive physical examination of the left shoulder. There is no evidence of a significant musculoskeletal or neurological deficit. The medical necessity for skilled physical therapy for the left shoulder has not been established. As such, the request is not medically necessary at this time.

Trazodone HCL 100mg #15 with 1 refill: Upheld

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

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

Decision rationale: The Official Disability Guidelines recommend trazodone as an option for insomnia, only for patients with potentially co-existing mild psychiatric symptoms such as depression or anxiety. In this case, the injured worker has continuously utilized the above medication since at least 10/2014. The injured worker does not maintain a diagnosis of insomnia disorder, nor a psychiatric disorder such as depression or anxiety. The medical necessity for the requested medication has not been established. It is also noted that the injured worker is utilizing Restoril 30 mg on an as needed basis for insomnia as well. As the medical necessity has not been established, the request cannot be determined as medically necessary at this time.