MAXIMUS Federal Services

Case Number:	CM14-0090338		
Date Assigned:	07/25/2014	Date of Injury:	10/27/2005
Decision Date:	09/19/2014	UR Denial Date:	05/16/2014
Priority:	Standard	Application Received:	06/16/2014

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 and Rehabilitation and is licensed to practice in California. 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 44-year-old male who reported an injury on 10/27/2005. The mechanism of injury was not provided for review; however, he reportedly sustained an injury to his left foot due to a crush injury. His treatment history included physical therapy, medications, and surgical intervention. He ultimately developed complex regional pain syndrome of the left lower extremity. He was evaluated on 05/08/2014. His medications included Alprazolam 0.5 mg, Lidoderm 5% patches, MS-Contin 60 mg, Percocet 10/325 mg, Soma 350 mg, and a Thermacare hand/wrist bandage. No physical examination was recorded at this examination. It was noted that he had pain complaints rated at a 3/10 to 8/10 and that he could ambulate greater than 1 city block without difficulty and was a low fall risk. His treatment plan included a refill of medications. A Request for Authorization was submitted on 05/09/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Alprazolam 0.5mg #60: Upheld

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

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

Decision rationale: The clinical documentation submitted for review does indicate that the injured worker has been on this medication for an extended duration of treatment. California Medical Treatment Utilization Schedule does not support the long term use of benzodiazepines as there is a high risk of physical and psychological dependence. The clinical documentation submitted for review does not provide any exceptional factors to support extending treatment beyond guideline recommendations. Therefore, continued use of this medication would not be supported. 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 Alprazolam 0.5 mg #60 is not medically necessary or appropriate.

Percocet 10/325mg #180: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-Going Management Page(s): 78.

Decision rationale: The California Medical Treatment Utilization Schedule recommends the ongoing use of opioids in the management of chronic pain be supported by 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 does provide evidence of a urine drug screen to evaluate the injured worker for aberrant behavior. The clinical documentation also indicates that the injured worker has 3/10 to 8/10 pain. However, a reduction in pain due to medications was not provided. Additionally, there is no documentation of functional benefit to establish efficacy of treatment. In the absence of this information, continued use of this medication would not be supported. 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 request Percocet 10/325 mg #180 is not medically necessary or appropriate.