

Case Number:	CM15-0014581		
Date Assigned:	02/02/2015	Date of Injury:	05/17/1999
Decision Date:	03/30/2015	UR Denial Date:	01/16/2015
Priority:	Standard	Application Received:	01/26/2015

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

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 42-year-old male who reported an injury on 05/17/1999 after his body was twisted in a conveyor belt. The injured worker reportedly sustained an injury to multiple body parts. The injured worker's treatment history included physical therapy, a home exercise program, radiofrequency ablations, and multiple medications. The injured worker was evaluated on 12/19/2014. It was documented that the injured worker's medications included Voltaren gel, Norco 5/325 mg, Lipitor 10 mg, and aspirin 81 mg. Objective findings included restricted range of motion of the cervical spine with cervical facet loading on the right. The injured worker's diagnoses included cervical pain and cervical facet syndrome. A request was made for a refill of medications. He was also prescribed cyclobenzaprine 10 mg. A Request for Authorization form was not submitted to support the request.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lidoderm 5% patch (700 mg/Patch) Apply 12 hours/day as needed #30 with 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112; 56-57.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112.

Decision rationale: The requested Lidoderm 5% patch (700 mg/patch) apply 12 hours/day as needed #30 with 1 refill is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends the use of this type of medication when the patient has failed to respond to first line medications to include anticonvulsants and antidepressants. The clinical documentation does not indicate that the injured worker has failed to respond to first line medications and requires a topical Lidoderm patch. Additionally, the request includes 1 additional refill. This does not allow for timely reassessment and evaluation of efficacy of this medication. As such, the requested Lidoderm 5% patch (700 mg/patch) apply 12 hours/day as needed #30 with 1 refill is not medically necessary or appropriate.

Trazodone 50 mg tablet 1-2 tablet as needed #60: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG-mental illness

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, Insomnia Treatments

Decision rationale: The requested trazodone 50 mg tablet 1-2 tablet as needed #60 is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does not address this medication. The Official Disability Guidelines recommend the use of sedating antidepressants to assist with insomnia related to chronic pain. The clinical documentation does not provide an adequate assessment of the injured worker's sleep hygiene to support the need for this medication. There is no documentation that the injured worker has failed to respond to nonpharmacological interventions to assist with restoration of sleep patterns. As such, the requested trazodone 50 mg tablet 1-2 tablet as needed #60 is not medically necessary or appropriate.

Duexis 800/26.6 mg BID #60: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Pain

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68.

Decision rationale: The requested Duexis 800/26.6 mg BID #60 is not medically necessary or appropriate. The clinical documentation submitted for review does not provide an adequate assessment of the injured worker's gastrointestinal system to support that they are at risk for development of gastrointestinal events related to medication usage. Therefore, the need for this medication is not supported. As such, the requested Duexis 800/26.6 mg BID #60 is not medically necessary or appropriate.

Percocet 10/325 mg tablet tid #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, specific drug list Page(s): 92.

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

Decision rationale: The requested Percocet 10/325 mg tablet tid #90 is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends the ongoing use of opioids in the management of chronic pain be supported by documented functional benefit, an assessment of pain relief, managed side effects, and evidence that the patient is monitored for aberrant behavior. The clinical documentation submitted for review does not provide any evidence that the injured worker is monitored for aberrant behavior. Additionally, there is no documentation that the injured worker has adequate pain relief or functional benefit resulting from medication usage. Therefore, continuation of this medication would not be supported. As such, the requested Percocet 10/325 mg tablet tid #90 is not medically necessary or appropriate.