

Case Number:	CM13-0021619		
Date Assigned:	01/10/2014	Date of Injury:	02/13/2006
Decision Date:	03/24/2014	UR Denial Date:	08/29/2013
Priority:	Standard	Application Received:	09/09/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Family Practice 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 physician 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 patient is a 62-year-old male who reported an injury on 02/13/2006 due to repetitive trauma while performing normal job duties. The patient ultimately underwent spinal fusion in 2006. The patient's chronic low back pain was managed with medications, biofeedback therapy, and physical therapy. The patient's most recent clinical evaluation documented the patient had limited range of motion of approximately 25% in all planes secondary to pain and tenderness to palpation in the lumbosacral musculature bilaterally. The patient's diagnoses included low back and lower extremity pain and lumbar radiculopathy. The patient's treatment plan included continuation of medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hydromorphone 8mg #240: Upheld

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

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

Decision rationale: The requested Hydromorphone 8 mg #240 is not medically necessary or appropriate. The clinical documentation submitted for review does indicate that this patient has

been on this medication for an extended period of time. The California Medical Treatment Utilization Schedule recommends the continued use of opioids be based on documentation of a quantitative assessment of pain relief and functional benefit and that the patient is monitored for aberrant behavior. The clinical documentation submitted for review does indicate that the patient is regularly monitored for aberrant behavior. However, there is no quantitative assessment of pain relief or documentation of functional benefit related to medication usage. Additionally, the requested quantity and amount of medication exceeds the recommended 120 Morphine equivalent dosage. Therefore, continued use of this medication is not supported by guideline recommendations. As such, the requested Hydromorphone 8 mg #240 is not medically necessary or appropriate.

Oxycontin 40mg #60: Upheld

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

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

Decision rationale: The requested OxyContin 40 mg is not medically necessary or appropriate. The clinical documentation submitted for review does indicate that this patient has been on this medication for an extended period of time. The California Medical Treatment Utilization Schedule recommends the continued use of opioids be based on documentation of a quantitative assessment of pain relief and functional benefit and that the patient is monitored for aberrant behavior. The clinical documentation submitted for review does indicate that the patient is regularly monitored for aberrant behavior. However, there is no quantitative assessment of pain relief or documentation of functional benefit related to medication usage. Additionally, the requested quantity and amount of medication exceeds the recommended 120 Morphine equivalent dosage. Therefore, continued use of this medication is not supported by guideline recommendations. As such, the OxyContin 40 mg is not medically necessary or appropriate.

Lunesta 3mg #30: Upheld

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

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 Lunesta 3 mg #30 is not medically necessary or appropriate. Official Disability Guidelines do support the use of this medication for insomnia induced by chronic pain. The clinical documentation however, does not provide an adequate assessment of the patient's sleep hygiene to support the efficacy of this medication. Therefore, continued use would not be supported. As such, the requested Lunesta 3 mg #30 is not medically necessary or appropriate

Lidoderm 5% 700mg patch #60: Upheld

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

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

Decision rationale: The requested Lidoderm 5% 700 mg patch #60 is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends the continued use of this medication be supported by documentation of functional benefit and pain relief. The clinical documentation submitted for review does not provide any evidence of functional benefit or pain relief related to the patient's medication usage. As such, continued use would not be supported. Therefore, the Lidoderm patch 5% 700 mg #60 is not medically necessary or appropriate.