

Case Number:	CM13-0034355		
Date Assigned:	12/06/2013	Date of Injury:	09/25/2012
Decision Date:	01/30/2014	UR Denial Date:	09/20/2013
Priority:	Standard	Application Received:	09/26/2013

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 Physical Medicine and Rehabilitation and is licensed to practice in Oklahoma and Texas. 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 46-year-old male who reported an injury on 09/25/2012 after moving a [REDACTED] energy drink cooler. The patient reported a popping sensation with associated burning radiating into the bilateral lower extremities. The patient was treated conservatively with physical therapy and medications. The patient was monitored for aberrant behavior with urine drug screens. The patient also underwent injection therapy without significant benefit. The patient's most recent clinical examination findings included restricted range of motion described as 0 degrees in extension, 12 inches from the floor in forward flexion, 10 degrees in lateral bending, and 10 degrees in axial rotation. The patient's medication schedule included MS Contin 50 mg, Percocet 10/325 mg, Neurontin 300 mg, Elavil 25 mg, and Temazepam 50 mg. The patient's diagnoses included lumbar radiculopathy, lumbago, lumbar strain, disc disorder of the lumbar spine, and disc disorder of the thoracic spine. The patient's treatment plan was to continue medication usage, continue seeing pain management, and apply heat to the injured body part.

IMR ISSUES, DECISIONS AND RATIONALES

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

Percocet 10/325mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of Opioids Page(s): 76-80.

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

Decision rationale: The request for Percocet 10/325 mg #60 is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient has continued pain complaints of the lumbar spine. California Medical Treatment Utilization Schedule recommends continued usage of opioids in the management of chronic pain be supported by functional benefit, pain assessment, managed side effects, and documentation of monitoring for aberrant behavior. The clinical documentation submitted for review does provide evidence that the patient is regularly monitored for aberrant behavior. However, there is no documentation of functional benefit or pain relief as a result of this medication. As such, the requested Percocet 10/325 mg #60 is not medically necessary or appropriate.

Temazepam (restoril) 15mg #60: Upheld

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

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

Decision rationale: The requested Temazepam is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient has continued low back complaints. California Medical Treatment Utilization Schedule does not recommend the extended use of benzodiazepines. Guidelines recommend duration be limited to approximately 4 to 6 weeks. The clinical documentation submitted for review does provide evidence that the patient has been on this medication for an extended duration. Therefore, continued use would not be indicated. Additionally, there is no documentation of increased functional benefit or symptom relief as a result of this medication. There are no exceptional factors noted within the documentation to support extending treatment beyond guideline recommendations. As such, the requested Temazepam 15 mg #60 is not medically necessary or appropriate.