MAXIMUS Federal Services

Case Number:	CM13-0038031		
Date Assigned:	12/18/2013	Date of Injury:	08/01/2007
Decision Date:	02/19/2014	UR Denial Date:	10/08/2013
Priority:	Standard	Application Received:	10/24/2013

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 Internal Medicine and Pulmonary Diseases 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 60-year-old male who reported an injury on 08/01/2007. The patient developed chronic low back pain and right knee pain as a result of a twisting injury while moving a large display. Prior treatments included physical therapy, epidural steroid injections, medial branch blocks, right total knee arthroplasty, psychiatric support, and medications. The patient was monitored for aberrant behavior via urine drug screens, and pill counts. The patient's most recent physical evaluation included a positive straight leg raising test bilaterally, tenderness to palpation over the lower lumbar facets, a positive bilateral facet loading test, and tenderness to the sacroiliac joints bilaterally. Physical findings of the right lower extremity included an antalgic gait with stiff-legged motion. The patient's diagnoses included chronic pain syndrome, disc displacement with radiculitis, degeneration of the lumbar or lumbosacral intervertebral discs, lumbosacral spondylosis without myelopathy, sacroiliitis, and status post knee joint replacement. The patient's treatment plan included testosterone serum testing and continued medication usage.

IMR ISSUES, DECISIONS AND RATIONALES

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

Opana ER 10mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 86.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 86.

Decision rationale: The prescription of Opana ER 10 mg #90 is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient has functional benefit and pain relief and is at low risk for aberrant behavior with this medication. However, the combination of medications that the patient is being prescribed exceeds the recommended dosage of 120 morphine equivalent doses. Therefore, continued use would not be supported by guideline recommendations. As such, the requested decision for 1 prescription of Opana ER 10 mg #90 is not medically necessary or appropriate.

Percocet 10/325mg #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 86.

Decision rationale: The prescription of Percocet 10/325 mg #120 is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient has functional benefit and pain relief and is at low risk for aberrant behavior with this medication. However, the combination of medications that the patient is being prescribed exceeds the recommended dosage of 120 morphine equivalent doses. Therefore, continued use would not be supported by guideline recommendations. As such, the requested decision for 1 prescription of Percocet 10/325 mg #120 is not medically necessary or appropriate.

A group of unknown testosterone cypionate oil 200mg/ml injections: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Pain Medications.

Decision rationale: The requested unknown testosterone cypionate oil 200 mg/mL injections are not medically necessary or appropriate. The Official Disability Guidelines state that testosterone replacement for hypogonadism related to opioids is "recommended in limited circumstances for patients taking high dose long-term opioids with documented low testosterone levels." The clinical documentation submitted for review does not provide an assessment of objective clinical findings of hypogonadism. Additionally, clinical documentation did not include the laboratory results that determined the patient had low testosterone levels. Therefore, the need for this medication cannot be determined. As such, the requested unknown testosterone ciliolate oil 200 mg/mL injections are not medically necessary or appropriate.