

Case Number:	CM13-0038064		
Date Assigned:	12/18/2013	Date of Injury:	05/30/2003
Decision Date:	04/30/2014	UR Denial Date:	10/17/2013
Priority:	Standard	Application Received:	10/24/2013

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 Internal Medicine, 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 patient is a 60-year-old male who reported an injury on 05/30/2003. The mechanism of injury was not provided for review. The patient's treatment history included multiple back surgeries, spinal stimulator implantation, and pain management with multiple medications. The patient's most recent clinical evaluation documented that the patient had 10/10 pain without medications reduced to a 2/10 to 3/10 pain with medications. It was noted that the patient's medication schedule allows the patient to remain functional, increase mobility and tolerate activities of daily living and participation in a home exercise program. The patient's most recent medication schedule included Percocet 10/325 mg, Avinza 60 mg, Zanaflex 6 mg, baclofen 20 mg, Lyrica 100 mg, Topamax 100 mg, Celebrex 200 mg, Ambien 12.5 mg, and oxycodone 10 mg. It was noted within the documentation that the patient had regular urine drug screens that were consistent and consistent CURES reporting. The patient's diagnoses included intervertebral lumbar disc disease without myelopathy, degenerative disc disease of the lumbar spine, pain in joints, rotator cuff syndrome, thoracic/lumbosacral neuritis/radiculitis, lumbago, and postlaminectomy syndrome of the lumbar region. The patient's treatment plan included continuation of medications and a urine drug screen.

IMR ISSUES, DECISIONS AND RATIONALES

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

TOPAMAX 100 MG, #60 TIMES 3: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines section on Antiepilepsy drugs Page(s): 16.

Decision rationale: The MTUS Chronic Pain Guidelines does recommend the use of anticonvulsants in the management of chronic pain. The MTUS Chronic Pain Guidelines recommend that continuation of medications in the management of chronic pain be supported by documented functional benefit, and an increase in functional capabilities. The clinical documentation submitted for review does indicate that the patient has reduced pain levels from a 10/10 to a 2/10 to 3/10 with medication usage and that medication allows for functional benefit. However, the clinical documentation indicates that the patient has a critical allergy to this medication. Although the patient has been on this medication for an extended duration of time, without any documentation of how the patient's critical allergy is managed, continued use of this medication would not be supported. As such, the requested Topamax 100 mg #60 times 3 is not medically necessary or appropriate.

AVINZA 60 MG, #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines section on Opioids Page(s): 78.

Decision rationale: The MTUS Chronic Pain Guidelines recommend ongoing use of opioids in the management of chronic pain is supported by documentation of a quantitative assessment of pain relief, functional benefit, managed side effects, and evidence that the patient is monitored for aberrant behavior. The clinical documentation submitted for review does indicate that the patient is monitored for aberrant behavior and has consistent urine drug screens and CURES reports. Additionally, it is documented that the patient has a reduction in pain from 10/10 without medications to 2/10 to 3/10 with medications. It is noted that the patient's medications provide for functional benefit and participation in activities of daily living and a home exercise program. However, the request as it is written does not provide a frequency of treatment. Therefore, the appropriateness of the request itself cannot be determined. As such, the request for Avinza 60 mg #60 is not medically necessary or appropriate.

PERCOCET 10-325 MG, #240: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines section on Opioids Page(s): 78.

Decision rationale: The MTUS Chronic Pain Guidelines recommend ongoing use of opioids in the management of chronic pain is supported by documentation of a quantitative assessment of pain relief, functional benefit, managed side effects, and evidence that the patient is monitored for aberrant behavior. The clinical documentation submitted for review does indicate that the patient is monitored for aberrant behavior and has consistent urine drug screens and CURES reports. Additionally, it is documented that the patient has a reduction in pain from 10/10 without medications to 2/10 to 3/10 with medications. It is noted that the patient's medications provide for functional benefit and participation in activities of daily living and a home exercise program. However, the request as it is written does not provide a frequency of treatment. Therefore, the appropriateness of the request itself cannot be determined. As such, the request Percocet 10/325 mg #240 is not medically necessary or appropriate.