

Case Number:	CM13-0057978		
Date Assigned:	12/30/2013	Date of Injury:	08/16/2002
Decision Date:	04/07/2014	UR Denial Date:	11/18/2013
Priority:	Standard	Application Received:	11/26/2013

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 Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in Florida. He/she has been in active clinical practice for more than five years and is currently working least at 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 57-year-old male who reported an injury on 08/16/2002. The patient ultimately underwent lumbar fusion from the L4-S1 levels. The patient developed chronic intractable pain that was managed with multiple medications. The patient's medication schedule included Percocet 10/325 mg, Valium 10 mg, Terocin topical solution, Diovan, and Oxycontin. The patient's most recent clinical evaluation documented that the patient had a positive straight leg raising test to the right and limited lumbar range of motion secondary to pain. The patient's diagnoses included bilateral lumbar radiculopathy, failed back surgery syndrome, severe deconditioning, and chronic intractable pain. The patient's treatment plan included a gym membership and continued use of medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

Percocet 10/325mg #90: Upheld

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

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 #90 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends continued use of opioids in the management of a patient's chronic pain be supported by documentation of functional benefit, a quantitative assessment of pain relief, managed side effects, and evidence that the patient is monitored for aberrant behavior. The clinical documentation submitted for review does provide evidence that the patient is monitored for aberrant behavior with urine drug screens. However, clinical documentation fails to provide any evidence of significant pain relief regarding medication usage. The patient's most recent documentation indicates that the patient has 6/10 pain. However, there is no evidence of pain relief from medication usage. Additionally, there is no documented functional improvement as a result of medication usage. Therefore, continued use would not be supported. As such, the requested Percocet 10/325 mg #90 is not medically necessary or appropriate.

The request for Terocin topical solution 2 120g bottles: Upheld

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

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

Decision rationale: The requested Terocin topical solution two 120 g bottles are not medically necessary or appropriate. The requested medication is a compounded medication that contains methyl salicylate, capsaicin, menthol, and lidocaine. California Medical Treatment Utilization Schedule recommends the use of methyl salicylate and menthol in the management of a patient's osteoarthritic pain. The clinical documentation does not provide any evidence that the patient's pain is osteoarthritic in nature. Additionally, California Medical Treatment Utilization Schedule recommends capsaicin as a topical agent after the patient has failed to respond to all first-line treatments. The clinical documentation submitted for review fails to provide any evidence that the patient has failed to respond to first-line medications to include antidepressants and anticonvulsants. Additionally, California Medical Treatment Utilization Schedule does not support the use of lidocaine in a cream or gel formulation as it is not FDA-approved to treat neuropathic pain in this formulation. California Medical Treatment Utilization Schedule states that any compounded agent with an element that is not recommended is not supported by guideline recommendations. As such, the requested Terocin topical solution two 120 g bottles is not medically necessary or appropriate.

Diovan 10mg #270: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Diabetes Chapter, Hypertension treatment.

Decision rationale: The requested Diovan 10 mg #270 is not medically necessary or appropriate. Official Disability Guidelines do recommend this type of medication as a first-line treatment for hypertension. However, the clinical documentation fails to consistently provide any indications that the patient is hypertensive. Additionally, there is no documentation of blood pressure measurements to determine the need for continued use of this medication. There is no evidence that the patient self-monitors blood pressure measurements. Therefore, the need to continue the use of this medication is not supported by the documentation. As such, the requested Diovan 10 mg #270 is not medically necessary or appropriate.

Oxycontin CR 20mg #20: Upheld

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

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

Decision rationale: The requested Oxycontin CR 20 mg #20 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends continued use of opioids in the management of a patient's chronic pain be supported by documentation of functional benefit, a quantitative assessment of pain relief, managed side effects, and evidence that the patient is monitored for aberrant behavior. The clinical documentation submitted for review does provide evidence that the patient is monitored for aberrant behavior with urine drug screens. However, clinical documentation fails to provide any evidence of significant pain relief regarding medication usage. The patient's most recent documentation indicates that the patient has 6/10 pain. However, there is no evidence of pain relief from medication usage. Additionally, there is no documented functional improvement as a result of medication usage. Therefore, continued use would not be supported. As such, the requested Oxycontin CR 20 mg #20 is not medically necessary or appropriate.