

Case Number:	CM13-0062851		
Date Assigned:	12/30/2013	Date of Injury:	03/24/2008
Decision Date:	04/22/2014	UR Denial Date:	11/18/2013
Priority:	Standard	Application Received:	12/09/2013

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 Orthopedic Surgery, 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 43 year old male who reported an injury on 03/24/2008. The mechanism of injury was not specifically stated. The patient is diagnosed with overuse syndrome of the right knee, status post arthroscopy with meniscectomy of the left knee, right hip degenerative joint disease, lumbar stenosis, lumbar disc degeneration, radiculopathy and status post an L4-5 laminotomy and foraminotomy in 08/2010. The patient was seen by [REDACTED] on 10/10/2013. The patient reported persistent lower back, bilateral knee and right ankle pain, rated an 8/10. Physical examination of the lumbar spine revealed tenderness to palpation with decreased sensation over the lateral aspect of the knee as well as slightly diminished range of motion. Treatment recommendations included a followup in 4 to 6 weeks and the continuation of current medications. It was also noted that the patient was pending authorization for a lumbar discogram as well as a referral to [REDACTED].

IMR ISSUES, DECISIONS AND RATIONALES

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

RESTORIL 30MG #30 WITH 5 REFILLS: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS 2009 Chronic Pain, Medical Treatment Guidelines, Benzodiazepines, page 24.

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

Decision rationale: The MTUS Chronic Pain Guidelines state benzodiazepines are not recommended for long-term use, because long-term efficacy is unproven and there is a risk of dependence. As per the documentation submitted, the patient has utilized Restoril 30 mg since at least 09/2012. However, there is no documentation of chronic insomnia or sleep disturbance. There is also no indication of functional improvement as a result of the ongoing use of this medication. As the MTUS Guidelines do not recommend long-term use of the medication, the current request is not medically necessary and appropriate.

180 OXYCONTIN 60MG: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS 2009 Chronic Pain, Opioids, Criteria for Use, pages 76-80.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines section on Opioids Page(s): 74-82.

Decision rationale: The MTUS Chronic Pain Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of nonopioid analgesics. Baseline pain and functional assessments should be made. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. As per the documentation submitted, the patient has utilized this medication since at least 2012. Despite ongoing use, the patient continues to report high levels of pain. The patient's physical examination continues to reveal an antalgic gait, restricted range of motion, and tenderness to palpation in the lumbar spine and bilateral knees. Although it is stated that the patient has used this medication in the past with significant improvement in overall pain, there was no documentation of objective functional improvement. Therefore, ongoing use of this medication cannot be determined as medically appropriate. As such, the request is not medically necessary and appropriate.

180 PERCOCET 10/325MG: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS 2009 Chronic Pain, Opioids, Criteria for Use, pages 76-80.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines section on Opioids Page(s): 74-82.

Decision rationale: The MTUS Chronic Pain Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of nonopioid analgesics. Baseline pain and functional assessments should be made. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. As per the

documentation submitted, the patient has utilized this medication since at least 2012. Despite ongoing use, the patient continues to report high levels of pain. The patient's physical examination continues to reveal an antalgic gait, restricted range of motion, and tenderness to palpation in the lumbar spine and bilateral knees. Although it is stated that the patient has used this medication in the past with significant improvement in overall pain, there was no documentation of objective functional improvement. Therefore, ongoing use of this medication cannot be determined as medically appropriate. As such, the request is not medically necessary and appropriate.