MAXIMUS Federal Services

Case Number:	CM13-0069631		
Date Assigned:	01/03/2014	Date of Injury:	09/03/1998
Decision Date:	06/30/2014	UR Denial Date:	11/25/2013
Priority:	Standard	Application Received:	12/23/2013

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 Physical Medicine and Rehabilitation and is licensed to practice in 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 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 injured worker is a 61-year-old male who reported an injury on 09/03/1998 due to a motor vehicle accident. The injured worker underwent an MRI of the lumbar spine on 12/18/2012 that concluded that the injured worker had disc bulging at the L1 and L2 impressing upon the thecal sac, disc bulging at the L2-3 impressing upon the thecal sac, disc bulging at the L3-4 impressing upon the thecal sac, evidence of interbody fusion at the L4-5 with a solid fusion, and a disc bulge at the L5-S1 indenting on the thecal sac. The injured worker underwent an electrodiagnostic study on 01/07/2013 that documented there was evidence of L3 radiculopathy and L5 radiculopathy. It was documented that the injured worker had previously received caudal injections on 01/31/2011 and 03/14/2011. The injured worker was evaluated on 12/12/2013. It was documented that the injured worker had ongoing cervical and lumbar spine pain. Physical findings included restricted range of motion of the cervical spine with tenderness to palpation of the paravertebral musculoskeletal and a positive Spurling's test causing radiating pain into the bilateral upper extremities. An evaluation of the lumbar spine documented limited range of motion secondary to pain with a positive straight leg raising test at 90 degrees bilaterally. It was documented that the injured worker had decreased sensation in the C6-7 distribution and left L4-5 dermatomal distribution. The injured worker's medications included Ambien 10 mg, Fentanyl 75 mcg/hr, one (1) patch every two (2) days, oxycodone hydrochloride extended release 10 mg, Senna 8.6 mg, Voltaren 1% gel, Norco 10/325 mg, MS Contin CR 30 mg, and oxycodone hydrochloride CR 10 mg. The injured worker's treatment plan included a caudal epidural steroid injection and a refill of medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

FENTANYL PATCH 75 MCG/HR #15: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 93.

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

Decision rationale: The Chronic Pain Guidelines recommend the ongoing use of opioids in the management of chronic pain be supported by documented functional benefit, quantitative assessment of pain relief, managed side effects, and evidence that the injured worker is monitored for aberrant behavior. The clinical documentation submitted for review does not provide any evidence that the injured worker is monitored for aberrant behavior. Additionally, the request as it is submitted does not clearly define a frequency of treatment. In the absence of this information the appropriateness of the request itself cannot be determined. As such, the requested Fentanyl patch 75mcg/hr #15 is not medically necessary or appropriate.

LUMBAR EPIDURAL INJECTION VIA CAUDAL APPROACH: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 46.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections Page(s): 46.

Decision rationale: The Chronic Pain Guidelines recommend that repeat epidural steroid injections be supported by at least 50% pain relief for four to six (4 to 6) weeks with documented functional improvement. The clinical documentation submitted for review does indicate that the injured worker has previously undergone caudal epidural steroid injections. However, the efficacy and duration of relief was not provided to support an additional caudal epidural steroid injection. As such, the requested lumbar epidural steroid injection via caudal approach is not medically necessary or appropriate.

OXYCODONE HCL EXTENDED-RELEASE (ER) 10MG #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78.

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

Decision rationale: The Chronic Pain Guidelines recommend that the ongoing use of opioids in the management of chronic pain be supported by documented functional benefit, managed side effects, evidence that the injured worker is monitored for aberrant behavior, and a quantitative

assessment of pain relief. The clinical documentation submitted for review fails to provide a quantitative assessment of pain relief or documented functional improvement related to medication usage. Additionally, the clinical documentation fails to identify whether the injured worker is engaged in a pain contract and is monitored for aberrant behavior with urine drug screens. Furthermore, the request as it is submitted does not provide a frequency of treatment. In the absence of this information the appropriateness of the request itself cannot be determined. As such, the requested oxycodone hydrochloride extended-release (ER) 10mg #120 is not medically necessary or appropriate.

SENNA 8.6MG #90, WITH FIVE (5) REFILLS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 77. Decision based on Non-MTUS Citation Medline Plus, Senna, Online Database

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Initiating Therapy Page(s): 77.

Decision rationale: The Chronic Pain Guidelines recommend the prophylactic treatment of constipation when an injured worker is taking opioids to assist with chronic pain management. The clinical documentation does indicate that the injured worker has been taking this medication for an extended duration. However, the requested five (5) refills do not provide an adequate period for timely re-assessment and re-evaluation to establish the efficacy of the requested medication to support continued use. Furthermore, the request as it is submitted does not clearly identify duration of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Senna 8.6mg #90, with five (5) refills are not medically necessary or appropriate.

VOLTAREN 1% GEL, WITH FIVE (5) REFILLS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-112.

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

Decision rationale: The Chronic Pain Guidelines do not recommend the use of non-steroidal anti-inflammatory drugs (NSAIDs) as topical agents for extended durations of treatment. It is recommended that treatment duration should not exceed four (4) weeks. The request as it is submitted for five (5) refills exceeds this treatment recommendation. Additionally, the guidelines do not recommend the use of topical non-steroidal anti-inflammatory drugs to assist with spine-related pain. The clinical documentation supports that the injured worker's primary pain generators are the cervical and lumbar spine. Therefore, the use of this medication would not be supported by guideline recommendations. Furthermore, the request as it is submitted does not clearly define duration of treatment or applicable body part. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Voltaren 1% gel, with five (5) refills are not medically necessary or appropriate.