

Case Number:	CM14-0009445		
Date Assigned:	02/14/2014	Date of Injury:	09/15/2008
Decision Date:	07/28/2014	UR Denial Date:	01/13/2014
Priority:	Standard	Application Received:	01/24/2014

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 Occupational 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 32-year-old male who has filed a claim for low back pain and lumbar radiculopathy associated with an industrial injury date of September 15, 2008. Review of progress notes indicates low back pain occasionally radiating down the back of both legs up to the feet. Patient reports persistence of urinary issues as preoperatively. Patient reports sleep difficulties, waking up secondary to pain and positional changes. Findings include antalgic gait; moderate stiffness, guarding, and hypertonicity; decreased lumbar range of motion; some tenderness over the left SI joint and gluteal muscles; and slightly decreased motor strength of lumbopelvic stabilizers and hip stabilizers. MRI of the lumbar spine dated October 02, 2013 showed post-surgical changes at L4-5 without evidence of residual or recurrent disc herniation, and a small disc protrusion at L3-4. Treatment to date has included opioids, sedatives, gabapentin, physical therapy and aquatherapy, home exercises, icing, lumbar epidural steroid injections, and lumbar surgeries, with the latest one (fusion) in June 2013. A utilization review from January 13, 2014 denied the requests for Dilaudid 4mg and Oxycontin 10mg as there was no clear indication of benefit derived from these medications or of medication use monitoring; Elavil 25mg as there was no discussion regarding sleep difficulties; methocarbamol 750mg as there was no documentation of acute exacerbations.

IMR ISSUES, DECISIONS AND RATIONALES

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

PRESCRIPTION OF DILAUDID 4MG, 1 TABLET EVERY 8 HOURS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, OPIOIDS (FOR CHRONIC PAIN) Page(s): 81.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use; On-Going Management Page(s): 78-82.

Decision rationale: As noted on pages 78-82 of the CA MTUS Chronic Pain Medical Treatment Guidelines, there is no support for ongoing opioid treatment unless there is ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Patient has been on this medication since at least June 2013. However, there is no documentation regarding symptomatic improvement or objective functional benefits derived from this medication, or of periodic urine drug screens to monitor medication use. The requested quantity is not specified. Therefore, the request for Dilaudid 4mg was not medically necessary.

PRESCRIPTION OF OXYCONTIN 10MG, TWICE A DAY: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, OPIOIDS (FOR CHRONIC PAIN) Page(s): 81.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use; On-Going Management Page(s): 78-82.

Decision rationale: As noted on pages 78-82 of the CA MTUS Chronic Pain Medical Treatment Guidelines, there is no support for ongoing opioid treatment unless there is ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Patient has been on this medication since at least June 2013. However, there is no documentation regarding symptomatic improvement or objective functional benefits derived from this medication, or of periodic urine drug screens to monitor medication use. The requested quantity is not specified. Therefore, the request for Oxycontin 10mg was not medically necessary.

PRESCRIPTION OF ELAVIL (FOR SLEEP), 25MG EVERY NIGHT: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, ANTIDEPRESSANTS Page(s): 13-14.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain Page(s): 13-15.

Decision rationale: According to pages 13-15 of CA MTUS Chronic Pain Medical Treatment Guidelines state that tricyclics are considered first-line agents for neuropathic pain, especially when accompanied by insomnia, anxiety, or depression. It is a possible option for non-neuropathic pain in depressed patients. Amitriptyline is also effective for fibromyalgia and CPRS. There is less evidence to support the use of sedating antidepressants for insomnia, but

may be an option in patients with coexisting depression. Patient has been on this medication since at least October 2013. The patient reports getting about 2-3 hours of sleep at a time, waking up secondary to pain and positional changes. However, this medication is not primarily indicated for the treatment of insomnia. The patient does not present with coexisting depression to support the use of this medication. Also, the requested quantity is not specified. Therefore, the request for Elavil 25mg was not medically necessary.

PRESCRIPTION OF METHOCARBAMOL 750MG, FOUR TIMES A DAY: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, MUSCLE RELAXANTS (FOR PAIN) Page(s): 63.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63-66.

Decision rationale: As stated on CA MTUS Chronic Pain Medical Treatment Guidelines pages 63-66, non-sedating muscle relaxants are recommended with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP. They may be effective in reducing pain and muscle tension, and increasing mobility. However, they show no benefit beyond NSAIDs in pain and overall improvement. Methocarbamol has CNS depressant effects with related sedative properties. Patient has been on this medication since June 2013. However, there is no documentation of recent acute exacerbation of low back pain. Also, although the patient presents with hypertonicity and guarding of the lumbar musculature, this medication is not recommended for chronic use. The requested quantity is not specified. Therefore, the request for methocarbamol 750mg was not medically necessary.