

Case Number:	CM14-0101877		
Date Assigned:	07/30/2014	Date of Injury:	11/01/2000
Decision Date:	09/09/2014	UR Denial Date:	06/20/2014
Priority:	Standard	Application Received:	07/02/2014

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 Physical Medicine & Rehabilitation and is licensed to practice in Texas and Ohio. 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 63-year-old female who reported an injury on 11/01/2000 after removing a binder from an upper level bookshelf. The injured worker reportedly sustained an injury to her low back. The injured worker's treatment history included multiple medications, physical therapy, and epidural steroid injections. The injured worker was evaluated on 02/27/2014. It was noted that the injured worker had 10/10 with medications. The injured worker's medications included Elavil 50 mg, carisoprodol/Soma 350 mg, a fentanyl patch 100 mcg per hour, hydrocodone/APAP 10/325 mg, docusate sodium 100 mg, pantoprazole/Protonix 20 mg, and Ambien 10 mg. The injured worker's diagnoses included cervical disc displacement without myelopathy, degenerative disc disease of the lumbar spine, lumbar spinal stenosis, lumbar disc displacement without myelopathy, lumbago, and fibromyalgia. It is noted that the injured worker continued to use medications to improve function. A refill of medications was requested. No Request for Authorization was submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective review of Fentanyl patch 100mcg/hr QTY:10 DOS:2/27/14: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 48, 77, 78, 88.

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

Decision rationale: The retrospective review of a fentanyl patch 100 mcg per hour quantity of 10 for date of service 02/27/2014 is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends the ongoing use of opioids in the management of chronic pain be supported by documented functional benefit, evidence of pain relief, a quantitative assessment of pain relief, and evidence that the injured worker is monitored for aberrant behavior. The clinical documentation submitted for review indicated that the injured worker had 10/10 with medications on 02/27/2014. Although it is noted that the injured worker has increased function due to medication usage, there is no evidence of pain relief. Also, the clinical documentation failed to provide any evidence that the injured worker is engaged in a pain contract or is monitored for aberrant behavior. Therefore, ongoing use of this medication would not be supported. Furthermore, the request as it is submitted does not clearly identify a frequency of treatment. As such, the retrospective request for fentanyl patches 100 mcg per hour quantity of 10 for date of service 02/27/2014 is not medically necessary or appropriate.

Retrospective review of Carisoprodol-Soma 350mg QTY: 120 DOS:2/27/14: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 29, 65.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63.

Decision rationale: The retrospective review of carisoprodol/Soma 350 mg quantity of 120 for date of service 02/27/2014 is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends muscle relaxants for short durations of treatment not to exceed 2 to 3 weeks for acute exacerbations of chronic pain. The clinical documentation submitted for review does indicate that the injured worker has been on this medication since at least 01/2014. This, in combination with the requested refill of medications, exceeds the recommended duration of treatment. There are no exceptional factors noted to support extending treatment beyond guideline recommendations. Furthermore, the request as it is submitted does not clearly identify a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested carisoprodol/Soma 350 mg quantity of 120 for date of service 02/27/2014 is not medically necessary or appropriate.

Retrospective review of Hydrocodone/APAP 10/325mg QTY: 180 DOS:2/27/14: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 48, 77, 78, 88.

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

Decision rationale: The retrospective review of hydrocodone/APAP 10/325 mg quantity of 180 for date of service 02/27/2014 is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends the ongoing use of opioids in the management of chronic pain be supported by documented functional benefit, evidence of pain relief, a quantitative assessment of pain relief, and evidence that the injured worker is monitored for aberrant behavior. The clinical documentation submitted for review indicated that the injured worker had 10/10 with medications on 02/27/2014. Although it is noted that the injured worker has increased function due to medication usage, there is no evidence of pain relief. Also, the clinical documentation failed to provide any evidence that the injured worker is engaged in a pain contract or is monitored for aberrant behavior. Therefore, ongoing use of this medication would not be supported. Furthermore, the request as it is submitted does not clearly identify a frequency of treatment. As such, the retrospective review of hydrocodone/APAP 10/325 mg quantity of 180 for date of service 02/27/2014 is not medically necessary or appropriate.