

Case Number:	CM14-0018580		
Date Assigned:	04/18/2014	Date of Injury:	05/01/2002
Decision Date:	06/30/2014	UR Denial Date:	02/03/2014
Priority:	Standard	Application Received:	02/13/2014

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, has a subspecialty in Pain Medicine, 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 52-year-old male who reported an injury on 05/01/2002 when he was pushed to the ground by a forklift. The injured worker reportedly sustained an injury to his left foot with fractures of the first and second metatarsals, lumbar contusion, and left groin and thigh pain. The injured worker ultimately developed reflex sympathetic dystrophy that was treated with physical therapy, multiple medications, and activity modifications. The injured worker's chronic opioid usage was monitored by urine drug screens. The injured worker's medications included Xanax 0.5 mg, Neurontin 300 mg, Omeprazole 40 mg, Ambien 10 mg, Lexapro 20 mg, methadone 10 mg, OxyContin 80 mg, and Roxicodone 30 mg. The injured worker was evaluated on 10/15/2013. It was documented that the injured worker had 7/10 pain with medications. Physical findings included motor strength weakness of the bilateral lower extremities rated 2/5 with tenderness to palpation of the bilateral lumbar musculature. The injured worker's diagnoses included reflex sympathetic dystrophy of the lower limb, low back pain, cervicgia, myofascial pain syndrome, and abdominal pain. A request was made for a refill of medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

PRESCRIPTION FOR METHADONE 10MG #180: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-Going Management And Opioids, Dosing Page(s): 77, 86.

Decision rationale: The requested methadone 10 mg #180 is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends ongoing documentation of a quantitative assessment of pain relief, functional benefit, managed side effects, and evidence that the injured worker is monitored for aberrant behavior to support continued use of opioid therapy. The clinical documentation submitted for review does indicate that the injured worker is monitored for aberrant behavior; however, the clinical documentation documents that the injured worker has 7/10 pain with medications. There is no quantitative assessment of pain without medications provided for review to establish efficacy of medication usage. Additionally, there was no documentation of functional benefit. The California Medical Treatment Utilization Schedule also recommends injured workers are provided opioid therapy not to exceed 120 morphine equivalents per day. The injured worker's medication schedule indicates that the injured worker is taking opioids well in excess of this recommendation. There are no exceptional factors noted within the documentation to support extending treatment beyond guideline recommendations. As such, the requested methadone 10 mg #180 is not medically necessary or appropriate. Also, the requested as it is submitted does not clearly identify a frequency of treatment. Therefore, the appropriateness of the request itself cannot be determined. The request is not medically necessary.

PRESCRIPTION FOR OXYCONTIN 80MG #270: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-Going Management And Opioids, Dosing, Page(s): 77, 86.

Decision rationale: The requested OxyContin 80 mg #270 is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends ongoing documentation of a quantitative assessment of pain relief, functional benefit, managed side effects, and evidence that the injured worker is monitored for aberrant behavior to support continued use of opioid therapy. The clinical documentation submitted for review does indicate that the injured worker is monitored for aberrant behavior; however, the clinical documentation documents that the injured worker has 7/10 pain with medications. There is no quantitative assessment of pain without medications provided for review to establish efficacy of medication usage. Additionally, there was no documentation of functional benefit. The California Medical Treatment Utilization Schedule also recommends injured workers are provided opioid therapy not to exceed 120 morphine equivalents per day. The injured worker's medication schedule indicates that the injured worker is taking opioids well in excess of this recommendation. There are no exceptional factors noted within the documentation to support extending treatment beyond guideline recommendations. As such, the requested OxyContin 80 mg #270 is not medically necessary or appropriate. Also, the requested as it is submitted does not clearly identify a frequency of treatment. Therefore, the appropriateness of the request itself cannot be determined and is thus not medically necessary.

PRESCRIPTION FOR ROXICODONE 30MG #360: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-Going Management And Opioids, Page(s): 77, 86.

Decision rationale: The requested Roxicodone 30 mg #360 is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends ongoing documentation of a quantitative assessment of pain relief, functional benefit, managed side effects, and evidence that the injured worker is monitored for aberrant behavior to support continued use of opioid therapy. The clinical documentation submitted for review does indicate that the injured worker is monitored for aberrant behavior; however, the clinical documentation documents that the injured worker has 7/10 pain with medications. There is no quantitative assessment of pain without medications provided for review to establish efficacy of medication usage. Additionally, there was no documentation of functional benefit. The California Medical Treatment Utilization Schedule also recommends injured workers are provided opioid therapy not to exceed 120 morphine equivalents per day. The injured worker's medication schedule indicates that the injured worker is taking opioids well in excess of this recommendation. There are no exceptional factors noted within the documentation to support extending treatment beyond guideline recommendations. As such, the requested Roxicodone 30 mg #360 is not medically necessary or appropriate. Also, the requested as it is submitted does not clearly identify a frequency of treatment. Therefore, the appropriateness of the request itself cannot be determined and is not medically necessary.