

Case Number:	CM14-0111943		
Date Assigned:	08/04/2014	Date of Injury:	03/03/1997
Decision Date:	09/10/2014	UR Denial Date:	07/09/2014
Priority:	Standard	Application Received:	07/18/2014

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 Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in Florida. 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 59-year-old female who reported an injury on 03/03/1997, due to an unknown mechanism of injury. The injured worker reportedly sustained an injury to her low back. The injured worker developed chronic low back pain that was managed with medications. The injured worker was monitored for aberrant behavior with urine drug screens. The injured worker was evaluated on 06/11/2014. It was documented that the injured worker had 7/10 pain of the low back that radiated into the bilateral lower extremities. It was documented that the injured worker had nausea related to medication usage. It was noted that the injured worker's sleep quality was poor and pain levels remained unchanged from the previous visit. The injured worker's medications included Desoxyn 5 mg, Gabapentin 600 mg, Lunesta 3 mg, Lyrica 50 mg, Norco 10/325 mg, OxyContin 40 mg, Provigil 200 mg, Zofran 8 mg, Ambien 5 mg, Losartan Potassium 25 mg, and Topamax 100 mg. Physical findings included restricted range of motion secondary to pain with tenderness to palpation of the spinous process at the L5 with a positive straight leg raising test bilaterally. The injured worker's diagnoses includes thoracic or lumbosacral neuritis/radiculitis, postlaminectomy syndrome; chronic pain syndrome; and lumbago. The injured worker's treatment plan included a refill of medications. A Request for Authorization to refill Gabapentin, Ambien, Desoxyn, Norco, OxyContin, and Provigil was submitted on 06/11/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325 #150: 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, page(s) 78 Page(s): 78.

Decision rationale: California Medical Treatment Utilization Schedule recommends the ongoing use of opioids in the management of chronic pain be supported by documented functional benefit, a quantitative assessment of pain relief, managed side effects, and evidence that the injured worker is monitored for aberrant behavior. The clinical documentation indicates that the injured worker has been on this medication since at least 01/2014. It is also noted that the injured worker is monitored for aberrant behavior. However, the clinical documentation does not provide any evidence of significant pain relief or functional benefit resulting from the use of this medication. Therefore, continued use would not be supported. 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 Norco 10/325 mg #150 is not medically necessary or appropriate.

Ambien 5mg #30: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Insomnia Treatment.

Decision rationale: California Medical Treatment Utilization Schedule does not address this request. Official Disability Guidelines recommend short duration of pharmacological intervention for insomnia related to chronic pain. The clinical documentation submitted for review does indicate that the injured worker has been on a sleep aid since at least 01/2014. The clinical documentation submitted for review does not provide any evidence that the injured worker has a significant response to the pharmacological interventions provided. It is noted within the documentation that the injured worker has continued poor sleep quality. Therefore, continued use of this medication would not be supported. Furthermore, the request as it is submitted does not clearly identify a frequency of treatment. Therefore, the appropriateness of the request itself cannot be determined. As such, the requested Ambien 5 mg #30 is not medically necessary or appropriate.

Oxycontin 40mg #270: Upheld

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

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

Decision rationale: California Medical Treatment Utilization Schedule recommends the ongoing use of opioids in the management of chronic pain be supported by documented functional benefit, a quantitative assessment of pain relief, managed side effects, and evidence that the injured worker is monitored for aberrant behavior. The clinical documentation indicates that the injured worker has been on this medication since at least 01/2014. It is also noted that the injured worker is monitored for aberrant behavior. However, the clinical documentation does not provide any evidence of significant pain relief or functional benefit resulting from the use of this medication. Therefore, continued use would not be supported. 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 OxyContin 40 mg, #270 is not medically necessary or appropriate.