

Case Number:	CM14-0128025		
Date Assigned:	08/15/2014	Date of Injury:	04/17/2001
Decision Date:	09/18/2014	UR Denial Date:	07/26/2014
Priority:	Standard	Application Received:	08/11/2014

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 and Rehabilitation and is licensed to practice in Nevada. 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 records, presented for review, indicate that this 53 year old male was reportedly injured on 4/17/2001. The mechanism of injury is undisclosed. The most recent progress note, dated 6/11/2014, indicated that there were ongoing complaints of thoracic and lumbar pain with pain that radiated into the right lower extremity. The physical examination demonstrated thoracic spine positive tenderness over the thoracic paraspinal muscles, tenderness noted at T8 to T9, restricted range of motion with pain on flexion, extension, and rotation, no evidence of gravitation, laxity, or instability noted, positive spasm left paraspinal muscles at T7 to T10 as well as left rhomboid, lumbar spine had an antalgic gait and lumbar scar and positive spasm at the lumbar paravertebral region. Atrophy or muscle wasting noted, positive tenderness at the right and left lumbar paravertebral regions in the left lumbar paravertebral regions in the L2 to L3, and L5 to S1 levels. Range of motion was with pain. Restricted range of motion. No recent diagnostic studies are available for review. Previous treatment included spinal fusion, medications, and conservative treatment. A request was made for Lyrica 50 milligrams quantity thirty with three refills, Oxycodone 15 milligrams quantity 84, OxyContin 40 milligrams quantity 112, OxyContin 20 milligrams quantity 28 and was not certified in the preauthorization process on 7/26/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lyrica 50mg #30 With 3 Refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 19, 99.

Decision rationale: Lyrica has been documented to be effective in treatment of diabetic neuropathy and postherpetic neuralgia, has Food and Drug Administration (FDA) approval for both indications, and is considered first-line treatment for both. This medication is designated as a Schedule V controlled substance because of its causal relationship with euphoria. (Blommel, 2007) This medication also has an antianxiety effect. After review of the medical documentation provided, there was no objective clinical findings of neuropathy or neuralgia on physical exam. Therefore, this request is deemed not medically necessary.

Oxycodone 15mg #84: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74, 78, 93.

Decision rationale: Medical Treatment Utilization Schedule (MTUS) guidelines support short acting opiates for the short term management of moderate to severe breakthrough pain. Management of opiate medications should include the lowest possible dose to improve pain and function, as well as the ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects. The claimant suffers from chronic pain; however, there is no clinical documentation of improvement in the pain or function with the current regimen. As such, this request is not considered medically necessary.

Oxycontin 40mg ER #112: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 75, 78, 92, & 97.

Decision rationale: Medical Treatment Utilization Schedule (MTUS) guidelines support long-acting opiates in the management of chronic pain when continuous around the clock analgesia is needed for an extended period of time. Management of opiate medications should include the lowest possible dose to improve pain and function, as well as the ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects. The claimant suffers from chronic pain; however, there is no documentation of improvement in the pain level or function with the current treatment regimen. In the absence of subjective or objective clinical data, this request is not considered medically necessary.

Oxycontin 20mg ER #28: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 75, 78, 92, & 97.

Decision rationale: Medical Treatment Utilization Schedule (MTUS) guidelines support long-acting opiates in the management of chronic pain when continuous around the clock analgesia is needed for an extended period of time. Management of opiate medications should include the lowest possible dose to improve pain and function, as well as the ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects. The claimant suffers from chronic pain; however, there is no documentation of improvement in the pain level or function with the current treatment regimen. In the absence of subjective or objective clinical data, this request is not considered medically necessary.