

Case Number:	CM14-0179407		
Date Assigned:	11/03/2014	Date of Injury:	05/03/2001
Decision Date:	12/22/2014	UR Denial Date:	09/25/2014
Priority:	Standard	Application Received:	10/29/2014

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, has a subspecialty in Interventional Spine 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 58 year old male with an injury date of 05/03/01. Based on the denial letter, the patient presents with chronic low back pain which he rates as a 6/10. He has a positive straight leg raise and has left sciatic notch tenderness. The patient is diagnosed with lower back pain. The utilization review determination being challenged is dated 09/25/14. Treatment reports are provided from 01/17/13- 09/29/14. All progress reports were hand written and illegible.

IMR ISSUES, DECISIONS AND RATIONALES

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

Methadone 10mg #240: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CRITERIA FOR USE OF OPIOIDS Page(s): 88,89,78.

Decision rationale: Based on the denial letter, the patient presents with chronic low back pain. The request is for Methadone 10 Mg #240. The report with the request was not provided. MTUS Guidelines page 88 and 89 states, "The patient should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument."

MTUS page 78 also requires documentation of the 4 A's (analgesia, ADLs, adverse side effects, and adverse behavior) as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. In this case, the treater fails to mention any specific changes in ADLs, aberrant behavior, or adverse side effects the patient may have had. There aren't any urine drug screens or CUREs report provided either. Due to lack of documentation, treatment is not medically necessary and appropriate.

Sertraline 100mg #135: Upheld

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

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

Decision rationale: Based on the denial letter, the patient presents with chronic low back pain. The request is for Sertraline 100 Mg #135. The report with the request was not provided. MTUS Guidelines page 13-15 states that "The main role of SSRIs may be in addressing psychological symptoms associated with chronic pain." Reviewing the records provided, there is no indication as to why the patient would need Sertraline, as there is no discussion of any psychological symptoms. There is no discussion as to how this medication has been effective in management of this patient's chronic pain either. Treatment is not medically necessary and appropriate.

Neurontin 600mg #270: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medication for chronic pain; Antiepilepsy drugs (AEDs), Gabapentin Page(s): 18-19; 60.

Decision rationale: Based on the denial letter, the patient presents with chronic low back pain. The request is for Neurontin 600 mg #270. The report with the request was not provided. It is not indicated when the patient began taking Neurontin, nor are there any discussion provided as to how Neurontin has benefited the patient. For gabapentin, MTUS requires, "The patient should be asked at each visit as to whether there has been a change in pain or function...combination therapy is only recommended if there is no change with first-line therapy, with the recommended change being at least 30%." MTUS page 60 requires documentation of pain and function with use of medications for chronic pain. There is no discussion provided on this report indicating Neurontin's efficacy. Treatment is not medically necessary and appropriate.