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| Case Number: | CM14-0033505 | | |
| Date Assigned: | 03/21/2014 | Date of Injury: | 12/15/2012 |
| Decision Date: | 04/25/2014 | UR Denial Date: | 02/14/2014 |
| Priority: | Standard | Application Received: | 03/18/2014 |

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 Anesthesiologist, 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 patient is a 31-year-old male who reported an injury on 12/15/2012. The patient reportedly tripped over loose concrete and injured his lower back. The patient is currently diagnosed with lumbar disc displacement without myelopathy, thoracic or lumbosacral neuritis or radiculitis, lumbar sprain and strain, and arthropathy not otherwise specified. The patient was seen by ■■■■■ on 02/03/2014. The patient reported 7/10 lower back pain with radiation to the right lower extremity. It was noted that the patient tolerated medications well and showed no evidence of medication dependency. Current medications at that time included Lyrica and Percocet. Physical examination on that date revealed restricted lumbar range of motion, tenderness to palpation, 5/5 motor strength in bilateral lower extremities, and intact sensation. Treatment recommendations at that time included a prescription for Butrans 10 mcg/hr, Lyrica 75 mg, Percocet 10/325 mg, and an L5-S1 lumbar epidural steroid injection.

IMR ISSUES, DECISIONS AND RATIONALES

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

BUTRANS 10,CG/HR PATCH APPLY 1 EVERY 7 DAYS: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 26-27.

Decision rationale: The California MTUS Guidelines state buprenorphine is recommended for treatment of opiate addiction. It is also recommended as an option for chronic pain after detoxification in patients who have a history of opiate addiction. As per the documentation submitted, the patient tolerated medication well and showed no evidence of medication dependency. The patient does not appear to meet criteria for the requested medication. There is no documentation of opiate addiction or detoxification. Based on the clinical information received, the request for BUTRANS 10, CG/HR PATCH APPLY 1 EVERY 7 DAYS is non-certified.

PERCOCET 10/325MG QTY #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

Decision rationale: The California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. As per the documentation submitted, the patient has utilized Percocet 10/325 mg every 4 to 6 hours since at least 12/2013. Despite ongoing use of this medication, the patient continues to report 7/10 back and right lower extremity pain. The patient also stated that medications are less effective to control symptoms. There is no change in the patient's physical examination that would indicate functional improvement. Based on the clinical information received and the California MTUS Guidelines, the request for PERCOCET 10/325MG QTY #30 is non-certified.

LUMBAR EPIDURAL STEROID INJECTION (LESI) L5-S1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation (ODG) OFFICIAL DISABILITY GUIDELINES

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 46.

Decision rationale: The California MTUS Guidelines state epidural steroid injections are recommended as an option for treatment of radicular pain, with use in conjunction with other rehab efforts. As per the documentation submitted, the patient's physical examination revealed 5/5 motor strength in bilateral lower extremities with intact sensation. It was also noted on 02/03/2014, the patient's EMG reports revealed normal findings. There was no imaging studies provided for review. There is also no documentation of unresponsiveness to conservative treatment. Based on the clinical information received, total hip replacement request for LUMBAR EPIDURAL STEROID INJECTION (LESI) L5-S1 is non-certified.