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| Case Number: | CM14-0035701 | | |
| Date Assigned: | 06/23/2014 | Date of Injury: | 03/05/1995 |
| Decision Date: | 08/19/2014 | UR Denial Date: | 03/10/2014 |
| Priority: | Standard | Application Received: | 03/24/2014 |

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 Illinois. 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 54-year-old female who reported an injury on 03/05/1995 after she bent over a copy machine which reportedly caused injury to the injured worker's low back. The injured worker's treatment history included medications, an epidural steroid injection, activity modifications, and physical therapy. The injured worker was evaluated on 03/01/2014. Physical findings included normal alignment of the lumbar spine with tenderness of the paraspinal region at the L4 and the iliolumbar region. It was noted that the patient had left sided tenderness to palpation of the paraspinal region of the left L4 and iliolumbar region with normal range of motion. The injured worker's diagnoses included degeneration of the lumbar intervertebral disc neurological deficit chronic pain syndrome. The injured worker's treatment plan included hydrocodone 10/325 mg and a Flector patch 1.3%. No justification for the request was provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

Flector patch 1.3% #60, 4 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesic. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medication for Chronic Pain Page(s): 60.

Decision rationale: The requested Flector patch 1.3% #60 with 4 refills is not medically necessary or appropriate. The clinical documentation submitted for review did not provide a medication history to support ongoing use of this medication. California Medical Treatment Utilization Schedule recommends medications used in the management of chronic pain be supported by documented functional benefit and evidence of pain relief. The clinical documentation submitted for review does not provide any evidence of pain relief or functional benefit related to the use of this medication. Additionally, the request includes 4 refills. This does not allow for timely reassessment and evaluation of efficacy. Furthermore, the request as it is submitted does not provide a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Flector patch 1.3% #60 with 4 refills is not medically necessary or appropriate.

Hydrocodone 10/325 #90, no refill: 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.

Decision rationale: The requested hydrocodone 100/325 mg #90 with no refills is not medically necessary or appropriate. The request contains what would be expected to be a typographical error as this medication's dosage is generally 10/325 mg. The California Medical Treatment Utilization Schedule recommends the ongoing use of opioids in the management of chronic pain be supported by documented functional benefit, quantitative assessment of pain relief, managed side effects, and evidence that the patient is monitored for aberrant behavior. The clinical documentation submitted for review does not provide any evidence that the patient has any pain relief or functional benefit resulting from the use of this medication. Additionally, there is no documentation that the patient is monitored for aberrant behavior. Furthermore, the request as it is submitted does not provide a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested hydrocodone 100/325 mg #90 with no refills is not medically necessary or appropriate.