

Case Number:	CM14-0039845		
Date Assigned:	06/27/2014	Date of Injury:	01/07/2003
Decision Date:	08/21/2014	UR Denial Date:	03/05/2014
Priority:	Standard	Application Received:	04/04/2014

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 & Rehabilitation and Pain Medicine and is licensed to practice in Texas and Oklahoma. 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 35-year-old female who reported an injury on 01/07/2003. The mechanism of injury was noted as she was preventing a patient from falling. Her diagnoses include failed back syndrome, medication dependency, and chronic radiculopathy. Her previous treatments included medication, acupuncture, aquatic therapy, a brace, chiropractic therapy, a spinal cord stimulator, a TENS unit, an independent exercise program, injections, and massage therapy. Per the clinical note dated 03/04/2014, the injured worker reported that she continued to have chronic pain in her low back and she reported the pain was increased with movement. She noted that without medications she was in bed and at times had a hard time caring for her child. The physician reported the patient had limited range of motion with flexion, extension, lateral flexion, and rotation in the lumbar region. She had muscle spasms in her bilateral lower extremities along with reduced sensation and muscle strength. The physician's treatment plan included prescriptions for Kadian 50 mg twice daily, Lyrica 100 mg 3 times daily, oxycodone 20 mg 3 times daily, Klonopin 1 mg, doxepin 10 mg at at bedtime, Zanaflex #15, Motrin 800 mg, Zantac 75 mg #60, and Neurontin 100 mg 3 to 4 times daily. The current request is for Klonopin 1 mg #30 with 1 refill, Doxepin 10 mg # 30 with 1 refill, and Oxycodone 20 mg # 90 with 1 refill. The rationale for the request was not provided. The request for authorization was provided on 03/04/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Klonopin 1 mg # 30 with 1 refill: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain (chronic).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

Decision rationale: The request for Klonopin 1 mg #30 with 1 refill is not medically necessary. The California MTUS Guidelines do not support the long term use of benzodiazepine medications as there is no proven efficacy with their use and the Guidelines limit use to 4 weeks. According to the documentation provided the injured worker had been prescribed this medication for over a year. The clinical documentation provided indicated the injured worker continued to have chronic low back pain and lower extremity pain, however, the physician failed to provide the efficacy of the medication. Therefore, despite the patient continuing to have chronic pain, and the guidelines state that Klonopin is not recommended for longer than 4 weeks. The current request also failed to indicate the frequency of the medication. As such, the request for Klonopin 1 mg #30 with 1 refill is not medically necessary.

Doxepin 10 mg # 30 with 1 refill: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain Page(s): 13.

Decision rationale: The request for Doxepin 10 mg # 30 with 1 refill is not medically necessary. The California MTUS Guidelines state that antidepressants for chronic pain are recommended as a first line option for neuropathic pain. Tricyclics are generally considered a first line agent unless they are ineffective, poorly tolerated, or contraindicated. Assessment of treatment efficacy should include not only pain outcomes but also an evaluation of function, changes in use of other analgesic medications, sleep quality and duration, and psychological assessment. The clinical documentation provided indicated the patient continued to have chronic neuropathic pain and was also prescribed Lyrica and Neurontin which were noted to be effective. However, there was no documentation to indicate the efficacy of doxepin. Therefore as the efficacy of the doxepin not being provided, the request would not be supported. The request also failed to provide the frequency of the medication. As such, the request for Doxepin 10 mg # 30 with 1 refill is not medically necessary.

Oxycodone 20 mg # 90 with 1 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, criteria for use Page(s): 78.

Decision rationale: The request for Oxycodone 20 mg # 90 with 1 refill is not medically necessary. The California MTUS Guidelines state the ongoing management of patients taking opioid medications should include routine office visits and detailed documentation of extend pain relief, functional status in regards to activities of daily living, appropriate medication use and/or aberrant drug taking behaviors, and adverse side effects. The pain assessment should include current pain, the least reported pain over the period since the last assessment, average pain, intensity of pain after taking the opioid, how long it takes for pain relief, and how long pain relief lasts. The clinical documentation submitted for review indicated the injured worker continued to have chronic pain; however, there was no documentation provided to indicate that a current pain assessment that documented the extent of pain relief, average pain, intensity of pain after taking the opioids, and how long the pain relief lasted. The documentation also failed to provide a current urine drug screen showing consistent results to verify appropriate medication. Therefore, in the absence of a pain assessment to indicate decreased pain and increased function with the use of opioids and a current urine drug screen to verify compliance, the criteria for ongoing use of opioid medication has not been met. The request also failed to provide the frequency of the medication. As such, the request for Oxycodone 20 mg # 90 with 1 refill is not medically necessary.