

Case Number:	CM14-0050400		
Date Assigned:	06/25/2014	Date of Injury:	08/08/1997
Decision Date:	07/22/2014	UR Denial Date:	03/18/2014
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 Anesthesiology, has a subspecialty in Pain Management 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:

According to the records made available for review, this is a 66-year-old female with an 8/8/97 date of injury, status post cervical laminectomy and fusion (undated), and status post low back surgery (undated). At the time (1/24/14) of request for authorization for OxyIR 15 mg #180, Fentanyl 75 mcg #15, and Toradol IM 60 mg #1, there is documentation moderate to severe low back, hips, and groin pain, decreased sensation of the left lower extremity, spasm in the left gluteal area, and positive straight leg raise. The patient's current diagnoses include lumbar degenerative disc disease, failed neck surgery syndrome with neck pain, and failed back surgery syndrome with bilateral hip pain. The patient's treatment to date included Oxycodone and Fentanyl patch since at least 8/8/13 and ongoing therapy with Zoloft and Flexeril. Regarding OxyIR 15 mg #180, there is no documentation that a continuous, around-the-clock analgesic is needed for an extended period of time; that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects; and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of use of OxyIR. Regarding Fentanyl 75 mcg #15, there is no documentation that a continuous, around-the-clock opioid administration is needed for an extended period of time; that the pain cannot be managed by other means; the patient has demonstrated opioid tolerance; no contraindications exist; and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of use of Fentanyl. Regarding Toradol IM 60 mg #1, there is no documentation that Toradol is being used as an alternative to opioid therapy and acute pain that requires analgesia at the opioid level.

IMR ISSUES, DECISIONS AND RATIONALES

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

OxyIR 15 mg #180: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Opioids, page(s) 80-81 Page(s): 80-81.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, page(s) 74-80 and Oxycodone, page 92 Page(s): page(s) 74-80; 92.

Decision rationale: The MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of moderate to severe pain when a continuous, around-the-clock analgesic is needed for an extended period of time, as criteria necessary to support the medical necessity of Oxycodone. In addition, the MTUS Chronic Pain Medical Treatment Guidelines identifies documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects, as criteria necessary to support the medical necessity of Oxycodone. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review there is documentation of diagnoses of lumbar degenerative disc disease, failed neck surgery syndrome with neck pain, and failed back surgery syndrome with bilateral hip pain. In addition, there is documentation of moderate to severe pain. However, there is no documentation that a continuous, around-the-clock analgesic is needed for an extended period of time. In addition, there is no documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Furthermore, given documentation of ongoing treatment with Oxycodone since at least 8/8/13, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of use of OxyIR. Therefore, based on guidelines and a review of the evidence, the request for OxyIR 15 mg #180 is not medically necessary.

Fentanyl 75 mcg #15: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, page(s) 44 & 47 Page(s): 44, 47.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines (Fentanyl Transdermal System), page(s) 44 Page(s): 44. Decision based on Non-MTUS Citation Non-MTUS Official Disability Guidelines (ODG) Pain, Duragesic and Fentanyl and Non-MTUS FDA.

Decision rationale: The MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of chronic pain in patients who require continuous opioid analgesia for pain that cannot be managed by other means, as criteria necessary to support the medical necessity of Duragesic. The MTUS Chronic Pain Medical Treatment Guidelines identifies that Duragesic is not recommended as first-line therapy. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. The ODG identifies documentation that Duragesic is not for use in routine musculoskeletal pain. The FDA identifies documentation of persistent, moderate to severe chronic pain that requires continuous, around-the-clock opioid administration for an extended period of time, and cannot be managed by other means; that the patient is already receiving opioid therapy, has demonstrated opioid tolerance, and requires a total daily dose at least equivalent to Duragesic 25 mcg/h; and no contraindications exist, as criteria necessary to support the medical necessity of Duragesic patch. Within the medical information available for review there is documentation of diagnoses of lumbar degenerative disc disease, failed neck surgery syndrome with neck pain, and failed back surgery syndrome with bilateral hip pain. In addition, there is documentation of persistent, moderate to severe chronic pain; that the patient is already receiving opioid therapy, and requires a total daily dose at least equivalent to Duragesic 25 mcg/h. However, there is no documentation that a continuous, around-the-clock opioid administration is needed for an extended period of time. In addition, given documentation of an associated request for Toradol injection and ongoing treatment with Zoloft and Flexeril, there is no documentation that the pain cannot be managed by other means. Furthermore, there is no documentation of opioid tolerance and no contraindications exist. Lastly, given documentation of ongoing treatment with Fentanyl since at least 8/8/13, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of use of Fentanyl. Therefore, based on guidelines and a review of the evidence, the request for Fentanyl 75 mcg #15 is not medically necessary.

Toradol IM 60 mg #1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 181, Table 8-8 NSAIDS, Chronic Pain Treatment Guidelines Page(s): 72. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Ketorolac (Toradol); NSAIDs.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Ketorolac (Toradol).

Decision rationale: The MTUS Chronic Pain Medical Treatment Guidelines identifies that Ketorolac (Toradol) is not indicated for minor or chronic painful conditions. The ODG identifies that Ketorolac, when administered intramuscularly, may be used as an alternative to opioid therapy. In addition, the ODG identifies documentation of moderately severe acute pain that requires analgesia at the opioid level, as criteria necessary to support the medical necessity of Toradol injection. Within the medical information available for review there is documentation of

diagnoses of lumbar degenerative disc disease, failed neck surgery syndrome with neck pain, and failed back surgery syndrome with bilateral hip pain. However, given documentation of the associated request for opioid medications, there is no documentation that Toradol is being used as an alternative to opioid therapy. In addition, given documentation of chronic pain, there is no documentation of acute pain that requires analgesia at the opioid level. Therefore, based on guidelines and a review of the evidence, the request for Toradol IM 60 mg #1 is not medically necessary.