

Case Number:	CM14-0063530		
Date Assigned:	07/11/2014	Date of Injury:	07/06/2004
Decision Date:	08/22/2014	UR Denial Date:	04/18/2014
Priority:	Standard	Application Received:	05/06/2014

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 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 50-year-old male who reported an injury on 7/6/04. The mechanism of injury was a fall. The diagnoses included status post lumbar fusion, chronic pain, opioid dependence, and failed spinal cord stimulator trial. The surgery included lumbar fusion. The previous treatments included medication, ultrasound, x-ray, MRI, and EMG. Within the clinical note dated 3/5/14 it was reported the injured worker complained of low back pain. The injured worker reported the pain radiated down predominantly the left lower extremity posterolateral aspect into the soles of his feet. He complained of mid back pain, bilateral shoulder, and neck pain. He rated his pain at 10/10 without medications and 6/10 with medications. Upon physical examination, the provider noted tenderness to palpation in the peri incisional and bilateral paraspinal and buttock regions. The medication regimen included OxyContin, Lyrica, Dexilant, gabapentin, oxycodone, and Ranitidine. The provider requested for refills on the medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

Oxycontin 60 mg:

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 80-83.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use Page(s): 78.

Decision rationale: The California MTUS Guidelines ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The guidelines recommend the use of urine drug screen or inpatient treatment for issues of abuse, addiction, or poor pain control. The provider did not document an adequate and complete pain assessment within the documentation. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. There is lack of documentation of the use of urine drug screen. The injured worker has been utilizing the medication since at least June 2004. Therefore, the request is not medically necessary.

Oxycodone 5 mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 80-83.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use Page(s): 78.

Decision rationale: The California MTUS Guidelines ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The guidelines recommend the use of urine drug screen or inpatient treatment for issues of abuse, addiction, or poor pain control. The provider did not document an adequate and complete pain assessment within the documentation. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. There is lack of documentation of the use of urine drug screen. The injured worker has been utilizing the medication since at least June 2004. Therefore, the request is not medically necessary.

Meloxicam 15 mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs Page(s): 67-68.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67-68.

Decision rationale: The California MTUS Guidelines indicate nonsteroidal anti-inflammatory agents have limited demonstrated efficacy in clinical trials that have been inconsistent with most studies being small and of short duration. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. The injured worker has been utilizing the medication since at least July 2004 which exceeds the guideline's recommendation of short-term use. Therefore, the request is not medically necessary.

