

<b>Case Number:</b>	CM14-0074847		
<b>Date Assigned:</b>	07/16/2014	<b>Date of Injury:</b>	11/08/1999
<b>Decision Date:</b>	09/23/2014	<b>UR Denial Date:</b>	05/09/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/22/2014

### 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 Nevada. 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 records presented for review indicate that this 47 year-old individual was reportedly injured on 11/8/1999. The mechanism of injury is noted as an industrial injury. The most recent progress note, dated 4/30/2014. Indicates that there are ongoing complaints of low back pain that radiates in the bilateral lower extremities. The physical examination demonstrated neurologic: deep tendon reflexes in the lower extremities or decrease but equal, absent ankle reflex on the right and trace positive reflex and left. Cervical spine: limited range of motion tenderness over the left cervical facets and palpable not the left shoulder. Left shoulder range of motion is limited with 45 motion. Positive tenderness to palpation over myofascial bands scapula on the left causing significant limitations in motion. Lumbar spine: positive tenderness to palpation midline to S-1. Limited range of motion with pain. Sciatic notch tenderness bilaterally. Positive straight leg raise sitting and lying down. Decreased sensation to light touch left L3-S1. No recent diagnostic studies are available for review. Previous treatment includes lumbar surgery, medications, and conservative treatment. A request had been made for Restoril 30mg #30, Duragesic 100mg #15, OxyContin 80mg #90, Oxycodone 5mg #240 and was not certified in the pre-authorization process on 5/9/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Restoril 30mg #30:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 24 of 127.

**Decision rationale:** The Expert Reviewer based his/her decision on the MTUS Chronic Pain Medical Treatment Guidelines, page 24 of 127. The Expert Reviewer's decision rationale: MTUS guidelines do not support benzodiazepines (Restoril) for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. As such, this request is not considered medically necessary.

**Duragesic 100 mcg #15:** 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): 44, 93 of 127.

**Decision rationale:** The Expert Reviewer based his/her decision on the MTUS Chronic Pain Medical Treatment Guidelines, page 44, 93 of 127. The Expert Reviewer's decision rationale: MTUS guidelines support long-acting opiates in the management of chronic pain when continuous around-the-clock analgesia is needed for an extended period of time. Management of opiate medications should include the lowest possible dose to improve pain and function, as well as the ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects. Treatment guidelines specifically state Fentanyl is "not recommended for musculoskeletal pain." Review of the available medical records, fails to document improvement in pain or function with the current treatment regimen. Given the date of injury, clinical presentation and current diagnosis, this request is not considered medically necessary.

**Oxycontin 80mg #90:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 75, 78, 92, & 97.

**Decision rationale:** The Expert Reviewer based his/her decision on the MTUS Chronic Pain Medical Treatment Guidelines, page 75, 78, 92, & 97. The Expert Reviewer's decision rationale: MTUS guidelines support long-acting opiates in the management of chronic pain when continuous around-the-clock analgesia is needed for an extended period of time. Management of opiate medications should include the lowest possible dose to improve pain and function, as well as the ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects. The claimant suffers from chronic pain; however, there is no documentation

of improvement in their pain level or function with the current treatment regimen. In the absence of subjective or objective clinical data, this request is not considered medically necessary.

**Oxycodone HCL 5mg #240:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 76-80.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 74, 78, 93 of 127.

**Decision rationale:** The Expert Reviewer based his/her decision on the MTUS Chronic Pain Medical Treatment Guidelines, 74, 78, 93 of 127. The Expert Reviewer's decision rationale: MTUS guidelines support short-acting opiates for the short-term management of moderate to severe breakthrough pain. Management of opiate medications should include the lowest possible dose to improve pain and function, as well as the ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects. The claimant suffers from chronic pain; however, there is no clinical documentation of improvement in their pain or function with the current regimen. As such, this request is not considered medically necessary.