

Case Number:	CM14-0075116		
Date Assigned:	08/08/2014	Date of Injury:	06/15/2000
Decision Date:	10/01/2014	UR Denial Date:	05/09/2014
Priority:	Standard	Application Received:	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 Texas. 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 56-year-old who sustained an injury on 06/15/00. No specific mechanism of injury was noted. The injured worker was followed for a history of severe low back pain radiating to the lower extremities. The injured worker had prior spinal cord stimulator placed with a recent exchange of battery in 11/15/13. The injured worker had prior lumbar fusion from L1 to L5. As of 05/01/14 the injured worker had been continuing to experience severe low back pain radiating to lower extremities. The injured worker felt that his medications were not working well with no results utilizing OxyContin. The injured worker denied any recent history of trauma. The last imaging studies were from 2011. Medications at this visit included Cymbalta Fentora Zolpidem Lexapro MiraLax morphine OxyContin Sumatriptan and Trazadone. Physical examination noted antalgic gait. The injured worker had severe subjective complaints. Medications were continued at this visit MRI of the thoracic spine and lumbar spine were also recommended. The requested imaging studies and medications for this injured worker were denied by utilization review on 05/09/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI Lumbar Spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) for Low Back regarding MRIs (magnetic resonance imaging)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

Decision rationale: In regards to MRI of the lumbar spine it is the opinion of this reviewer that the request is not medically necessary at this time. The injured worker did not present with any objective evidence of severe progressively worsening neurological deficits to support imaging studies at this time. None of the prior imaging studies were available for review. Given the absence of any specific neurological deficits or progressive worsening of neurological findings, the request for an MRI of the lumbar spine is not medically necessary or appropriate.

MRI Thoracic: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) for Low Back regarding MRIs (magnetic resonance imaging)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

Decision rationale: In regards to MRI of the thoracic spine it is the opinion of this reviewer that the request is not medically necessary at this time. The injured worker did not present with any objective evidence of severe progressively worsening neurological deficits to support imaging studies at this time. None of the prior imaging studies were available for review. Given the absence of any specific neurological deficits or progressive worsening of neurological findings, the request for an MRI of the thoracic is not medically necessary or appropriate.

Oxycontin 30 mg, ninety count: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of Opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for Use Page(s): 88-89.

Decision rationale: In regards to Oxycontin 30mg #90 it is the opinion of this reviewer that this request is not medically necessary. In review of the clinical documentation submitted for review there is no clear indication that OxyContin was providing any benefit to this injured worker. The 05/01/14 report indicated the injured worker was not obtaining any benefit from this medication. Per guidelines there should be ongoing evidence of the efficacy of narcotic agents such as OxyContin. Therefore, the request for Oxycontin 30 mg, ninety count, is not medically necessary or appropriate.

Trazodone 50 mg thirty count: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness and Stress Chapter: Trazadone (Desyrel)

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, Insomnia Treatment

Decision rationale: In review of the clinical documentation submitted for review this reviewer would not have recommended the request for Trazadone as medically necessary. Clinical documentation submitted for review did not specify the amount of benefit being obtained with this medication in terms of sleep improvement. Therefore, the request for Trazodone 50 mg thirty count is not medically necessary or appropriate.

Sumavel 1 injection, nine count: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Head Chapter Triptans

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

Decision rationale: In regards to Sumavel injection #9 it is the opinion of this reviewer that the request is not medically necessary. The clinical documentation submitted for review did not establish the efficacy of this medication in terms of functional benefit or pain reduction. Therefore, the request for Sumavel 1 injection, nine count, is not medically necessary or appropriate.

Colace: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter; Opioid-induced constipation treatment:

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Colace. (2013). In Physicians' desk reference 67th ed.

Decision rationale: In regards to Colace it is the opinion of this reviewer that the request is not medically necessary. The clinical documentation submitted for review did not establish the efficacy of this medication in terms of functional benefit. Furthermore, the request is not specific in regards of dose, quantity, frequency, or duration. Therefore, that the request for Colace is not medically necessary or appropriate.

Lidoderm: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm patch Page(s): 54.

Decision rationale: In regards to Lidoderm it is the opinion of this reviewer that the request is not medically necessary. The clinical documentation submitted for review did not establish the efficacy of this medication in terms of functional benefit or pain reduction. Furthermore, the request is not specific in regards of dose, quantity, frequency, or duration. Therefore, the request for Lidoderm is not medically necessary or appropriate.

Miralax: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter; Opioid-induced constipation treatment

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Miralax. (2013). In Physicians' desk reference 67th ed.

Decision rationale: In regards to Miralax it is the opinion of this reviewer that the request is not medically necessary. The clinical documentation submitted for review did not establish the efficacy of this medication in terms of functional benefit. Furthermore, the request is not specific in regards of dose, quantity, frequency, or duration. Therefore, the request is not medically necessary at this time.

Prilosec: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk.

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, proton pump inhibitors

Decision rationale: In regards to Prilosec it is the opinion of this reviewer that the request is not medically necessary. The clinical documentation submitted for review did not establish the efficacy of this medication in terms of functional benefit.. Furthermore, the request is not specific in regards of dose, quantity, frequency, or duration. Therefore, request for Prilosec is not medically necessary or appropriate.

Valium 5mg x60: Upheld

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

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

Decision rationale: In regards to the use of Valium 5mg quantity 60, this reviewer would not have recommended this medication as medically necessary based on the clinical documentation provided for review and current evidence based guideline recommendations. The chronic use of benzodiazepines is not recommended by current evidence based guidelines as there is no evidence in the clinical literature to support the efficacy of their extended use. The current clinical literature recommends short term use of benzodiazepines only due to the high risks for dependency and abuse for this class of medication. The clinical documentation provided for review does not specifically demonstrate any substantial functional improvement with the use of this medication that would support its ongoing use. Therefore, the request for Valium 5 mg, sixty count, is not medically necessary or appropriate.

Intermezzo 3.5 mg, thirty count,: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter; Insomnia treatment

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, Zolpidem

Decision rationale: In regards to the use of Intermezzo 3.5mg quantity 30, this reviewer would not have recommended this medication as medically necessary based on the clinical documentation provided for review and current evidence based guideline recommendations. The use of Intermezzo to address insomnia is recommended for a short term duration no more than 6 weeks per current evidence based guidelines. The clinical documentation submitted for review does not provide any indications that the use of Intermezzo has been effective in improving the claimant's overall functional condition. Therefore, the request for Intermezzo 3.5 mg, thirty count, is not medically necessary or appropriate.

Lexapro 10 mg, thirty count,: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants Page(s): 13-16.

Decision rationale: In regards to Lexapro 10mg quantity 30, it is the opinion of this reviewer that the request is not medically necessary. The clinical documentation submitted for review did not establish the efficacy of this medication in terms of functional benefit. Furthermore, the request is not specific in regards of dose, quantity, frequency, or duration. Therefore, the request for Lexapro 10 mg, thirty count, is not medically necessary or appropriate.

Fentora 400 mcg 1 Buccal, 28 count: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter; Fentora (fentanyl effervescent buccal tablet)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Opioids, Criteria for Use

Decision rationale: In regards to Fentora 400mcg quantity 28, it is the opinion of this reviewer that this request is not medically necessary. In review of the clinical documentation submitted for review there is no clear indication that Fentora was providing any benefit to this injured worker. The 05/01/14 report indicated the injured worker was not obtaining any benefit from this medication. Per guidelines there should be ongoing evidence of the efficacy of narcotic agents such as Fentora. As the clinical documentation submitted for review indicated the injured worker was not obtaining any substantial relief with this medication this reviewer would not have recommended this request as medically necessary.