

Case Number:	CM14-0077929		
Date Assigned:	07/18/2014	Date of Injury:	05/01/2002
Decision Date:	09/09/2014	UR Denial Date:	05/15/2014
Priority:	Standard	Application Received:	05/27/2014

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 Medicine 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 52-year-old male who sustained a crush injury to his left foot on 05/01/02. The records indicate that this was initially a diagnosis of a Lisfranc fracture. 10 days later, he developed low back pain. The serial records indicate that the injured worker has progressed to diffused chronic pain syndrome. He has a diagnosis of Reflex Sympathetic Dystrophy involving the left lower extremity. The submitted clinical records indicate that the injured worker has progressively digressed through the course of his treatment. Despite being on multiple opiates, his pain levels were reported to be 7/10. There are multiple utilization review recommendations for tapering of opiates. The record contains urine drug screens, which indicate compliance with the treatment plan. The most recent clinical notes indicate that he has low back pain with radiation into the left lower extremity. He has generalized back pain, sciatica, neck pain, myalgias, muscle weakness, and stiffness. He is reported to have insomnia and fatigue. On examination, he has decreased cervical range of motion and tenderness. On examination of the left lower extremity, he is noted to have ankle atrophy and swelling with the presence of a scar. He is noted to have tenderness with similar findings on the right. Medications include Methadone 10mg, Oxycontin 80mg, Roxycodone 30mg, Ambien 10mg, and Neurontin. The record contains a utilization review determination dated 05/15/14 in which requests for Ambien 10mg #30 with 4 refills, Neurontin 300mg #180, Oxycontin 80mg #270, and Roxycodone 30mg #360 were non-certified. The records notes that modifications were made for Neurontin and Oxycontin.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ambien 10mg #30 with 4 refills: 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 (Chronic).

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: The request for Ambien 10mg #30 with 4 refills is not supported as medically necessary. The submitted clinical records indicate that the injured worker has a diagnosis of reflex sympathetic dystrophy and chronic pain syndrome. The records note that the injured worker has sleep disturbance. Per Official Disability Guidelines, Ambien is clinically indicated for a period of 2-3 weeks to restore the normalization of sleep. It is not supported for the treatment of chronic sleep disturbance. Per the Official Disability Guidelines, Ambien should be discontinued at the normalization of sleep. Therefore, based on the information provided, the request is not supported as medically necessary.

Neurontin 300mg #180: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs) Page(s): 16-22.

Decision rationale: The request for Neurontin 300mg #180 is recommended as medically necessary. The submitted clinical records indicate that the injured worker has objective evidence of neuropathic pain for which this medication is clinically indicated. Therefore, this medication should be continued per both California Medical Treatment Utilization Schedule and Official Disability Guidelines. Therefore, the request is medically necessary.

Oxycontin 80mg #270: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIATES Page(s): 74-80.

Decision rationale: The submitted clinical records indicate that the injured worker is receiving Methadone and other opiate medications. The injured worker's Morphine equivalents far exceed the 120 morphine equivalents as supported under California Medical Treatment Utilization Schedule and Official Disability Guidelines. It would further be noted that the United States

Food and Drug Administration recommends no more than 100 Morphine equivalents per day. The records indicate that on multiple occasions the prescribing provider was recommended to wean the injured worker from this medication. There does not appear to be any effort on the prescribing provider to do so. Therefore, based on the information as provided, the continuation of this medication cannot be supported.

Roxicodone 30mg #360: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIATES Page(s): 74-80.

Decision rationale: The request for Roxycodone 30mg #360 is not supported as medically necessary. The submitted clinical records indicate that the injured worker is receiving Methadone and other opiate medications. The injured worker's Morphine equivalents far exceed the 120 morphine equivalents as supported under California Medical Treatment Utilization Schedule and Official Disability Guidelines. It would further be noted that the United States Food and Drug Administration recommends no more than 100 Morphine equivalents per day. The records indicate that on multiple occasions the prescribing provider was recommended to wean the injured worker from this medication. There does not appear to be any effort on the prescribing provider to do so. Therefore, based on the information as provided, the continuation of this medication cannot be supported. Therefore, the request is not medically necessary.