

Case Number:	CM14-0086835		
Date Assigned:	07/23/2014	Date of Injury:	10/19/2000
Decision Date:	09/12/2014	UR Denial Date:	05/23/2014
Priority:	Standard	Application Received:	06/10/2014

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 Illinois. 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 46-year-old male who reported injury on 10/19/2000. The mechanism of injury was not provided. The documentation indicated the injured worker's medications included oxycodone 3 mg, OxyContin 40 mg XR, trazodone HCL and temazepam as of 01/2014. The injured worker underwent an MRI of the cervical spine without contrast. The injured worker underwent a spinal fusion. The documentation of 04/23/2014 revealed the injured worker had complaints of chronic, severe neck pain. The injured worker noted he had extreme difficulty with swallowing. The average pain without medications was 10/10 and with medications 7/10. The injured worker indicated the medications kept him functional, increased his mobility and tolerance of activities of daily living and home exercises. There were no side effects noted. The injured worker's current medications included OxyContin 40 mg XR tab 12 hour, Restoril 30 mg capsules, Norco 10/325 mg tablets, trazodone HCL 100 mg tablets, quazepam 15 mg tablets and gabapentin 300 mg capsules. The physical examination revealed the injured worker had tenderness to palpation in the cervical spine. The injured worker had a positive straight leg raise bilaterally. The diagnoses included pain in joint shoulder region, unspecified disorders bursa and tendons shoulder region, displacement cervical intervertebral disc without myelopathy and degeneration of cervical intervertebral disc, cervicalgia, post laminectomy syndrome cervical region, and brachial neuritis or radiculitis. The treatment plan included starting the injured worker on quazepam 15 mg 1 tablet at bedtime as needed for sleep, OxyContin 40 mg XR 12 hour tablets up to 7 per day as needed, Restoril 30 mg capsules 2 at bedtime as needed for insomnia, Norco 10/325 mg tablets 1 by mouth 3 times a day as needed for pain, and trazodone HCL 100 mg tablets 1 at bedtime as needed for insomnia. There was a detailed DWC form RFA submitted for the request.

IMR ISSUES, DECISIONS AND RATIONALES

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

Oxycontin (oxycodone HCL), 40 mg, #105, with no refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids. Decision based on Non-MTUS Citation Official Disability Guidelines, Drug Formulary.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic pain, ongoing management, opioid dosing Page(s): 60, 78, 86.

Decision rationale: The California MTUS Guidelines recommend opiates for the treatment of chronic pain. There should be documentation of objective functional improvement, and objective decrease in pain and documentation the injured worker is being monitored for aberrant drug behavior and side effects. The clinical documentation submitted for review indicated the injured worker had an objective decrease in pain, and that the injured worker was being monitored for aberrant drug behavior and side effects. The documentation indicated the injured worker had objective functional benefit. The duration of use was noted to be at least 3 months. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Oxycontin (oxycodone HCL), 40 mg, #105, with no refills is not medically necessary.

Trazodone HCL, 100 MG, #15, with 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants. Decision based on Non-MTUS Citation Official Disability Guidelines, Drug Formulary.

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

Decision rationale: The California MTUS Guidelines recommend antidepressants as a first line medication for the treatment of neuropathic pain and they are recommended especially if the pain is accompanied by insomnia, anxiety or depression. The clinical documentation submitted for review indicated the injured worker had utilized the medication for at least 3 months. There was a lack of documentation indicating the necessity for 1 refill without re-evaluation. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for trazodone HCL, 100 mg, #15 with 1 refill is not medically necessary.

Norco (hydrocodone/acetaminophen), 10/325 mg, #45, with 1 refill: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic pain, ongoing management, opioid dosing Page(s): 60, 78, 86.

Decision rationale: The California MTUS Guidelines recommend opiates for the treatment of chronic pain. There should be documentation of objective functional improvement, and objective decrease in pain and documentation the injured worker is being monitored for aberrant drug behavior and side effects. The clinical documentation submitted for review indicated the injured worker had an objective decrease in pain, and that the injured worker was being monitored for aberrant drug behavior and side effects. The documentation indicated the injured worker had objective functional benefit. The duration of use was noted to be at least 3 months. The request as submitted failed to indicate the frequency for the requested medication. The clinical documentation submitted for review failed to provide documentation of a necessity for 1 refill without re-evaluation. Given the above, the request for Norco (hydrocodone/acetaminophen), 10/325 mg, #45, with 1 refill is not medically necessary.

Restoril, 30 mg, #30, with 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines. Decision based on Non-MTUS Citation Official Disability Guidelines.

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

Decision rationale: The California MTUS Guidelines do not recommend the use of benzodiazepines as a treatment for injured workers with chronic pain for longer than 3 weeks due to a high risk of psychological and physiological dependency. The duration of use was noted to be at least 3 months. There was a lack of documentation of efficacy and documented rationale for the requested medication. The request as submitted failed to indicate the frequency for the requested medication. There was a lack of documentation indicating a necessity for 1 refill without re-evaluation. Given the above, the request for Restoril 30 mg #30 with 1 refill is not medically necessary.