MAXIMUS Federal Services

Case Number:	CM14-0089360		
Date Assigned:	07/23/2014	Date of Injury:	11/09/2004
Decision Date:	08/29/2014	UR Denial Date:	05/21/2013
Priority:	Standard	Application Received:	06/13/2014

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 and Ohio. 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 49-year-old male who reported an injury on 11/09/2004 due to an unknown mechanism of injury. The injured worker reportedly sustained an injury to his low back. The injured worker was evaluated on 05/09/2014. It was documented that the injured worker complained of chronic low back pain that radiated into the right lower extremity. The injured worker's medications included OxyContin, Percocet and Lyrica. The injured worker's diagnoses included chronic pain, lumbar radiculitis and chronic back pain. Physical findings included limited range of motion of the lumbar spine secondary to pain with decreased sensation over the right ankle and foot. A Request for Authorization dated 05/14/2014 for a refill of medications was submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Oxycontin 80mg QTY: 120.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids On-Going Management; Oxymorphone Page(s): 78-82, 93.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-Going Management Page(s): 78.

Decision rationale: The requested OxyContin 80 mg (Quantity: 120.00) is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends that the ongoing use of opioids in the management of chronic pain be supported by documented functional benefit, a quantitative assessment of pain relief, managed side effects and evidence that the injured worker is monitored for aberrant behavior. The clinical documentation submitted for review does not provide any evidence that the injured worker is monitored for aberrant behavior. Additionally, there is no documentation of functional benefit or a quantitative assessment of pain relief resulting from the use of this medication. Therefore, the ongoing use would not be supported. Furthermore, the request as it is submitted does not clearly identify a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested OxyContin 80 mg (Quantity: 120.00) is not medically necessary.

Percocet 5mg-325mg QTY: 100: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids On-Going Management;Oxymorphone.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-Going Management Page(s): 78.

Decision rationale: The requested Percocet 5/325 mg (Quantity: 100.00) is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends that the ongoing use of opioids in the management of chronic pain be supported by documented functional benefit, a quantitative assessment of pain relief, managed side effects and evidence that the injured worker is monitored for aberrant behavior. The clinical documentation submitted for review does not provide any evidence that the injured worker is monitored for aberrant behavior. Additionally, there is no documentation of functional benefit or a quantitative assessment of pain relief resulting from the use of this medication. Therefore, the ongoing use would not be supported. Furthermore, the request as it is submitted does not clearly identify a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Percocet 5/325 mg (Quantity: 100.00) is not medically necessary.

Ambien CR 12.5mg QTY: 30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Work Data Loss Institute, Official Disability Guidelines (ODG) Treatment in Workers Compensation 5th edition, Pain (Chronic), Zolpidem (Ambien).

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 Treatments.

Decision rationale: The requested Ambien CR 12.5 mg (Quantity: 30.00) is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does not address this type of medication. The Official Disability Guidelines recommend the use of this medication for short durations of treatment. The clinical documentation does indicate that the injured worker has been on Ambien for an extended duration of time. Therefore, continued use would not be supported. The clinical documentation fails to provide any evidence of functional benefit and better sleep hygiene resulting from the use of this medication. Furthermore, the request as it is submitted does not clearly identify a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Ambien CR 12.5 mg (Quantity: 30.00) is not medically necessary