

Case Number:	CM14-0094712		
Date Assigned:	07/25/2014	Date of Injury:	12/20/1996
Decision Date:	09/29/2014	UR Denial Date:	06/10/2014
Priority:	Standard	Application Received:	06/23/2014

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 61-year-old individual was reportedly injured on December 20, 1996. The mechanism of injury was noted as a motor vehicle collision and physical assault. The most recent progress note, dated June 5, 2014, indicated that there were ongoing complaints of low back pain. The physical examination demonstrated a 5 feet 11 inch, 213 pound individual who was normotensive (112/74). There were no changes reported to the physical examination. The gait pattern was described as slow antalgic. A single point cane was required. Muscle spasms were noted in the lower lumbar spine associated with a decrease in lumbar range of motion. Lower extremity sensation was reported to be 4/5 and motor function strength was described as 5/5. Diagnostic imaging studies objectified and were not reported. Previous treatment included physical therapy, epidural steroid injections, Transcutaneous Electrical Nerve Stimulation (TENS) and a lumbar brace. A request had been made for medications and was not certified in the pre-authorization process on June 11, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Fentanyl Patch 25 mcg #15: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 44, 47, 78, 86.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009 Page(s): 44, 93 of 127.

Decision rationale: The Expert Reviewer based his/her decision on the MTUS Chronic Pain Medical Treatment Guidelines, pages 44, 93. The Expert Reviewer's decision rationale: As outlined in the MTUS, there was support for long acting opioids in the management of chronic pain when continuous around-the-clock analgesia was needed. However, management of opioids are to be the lowest possible level to improve function and decreased pain. The progress notes indicate that the pain complaints are unchanged, and the functional level was unchanged, and there was no clear clinical indication that this medication was having any efficacy whatsoever. While noting that there were ongoing complaints of pain, there was no objectification of any improvement. Therefore, the request is not medically necessary.

Dilaudid 8 mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 75, 78, 86.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26; MTUS (Effective July 18, 2009 Page(s): 74-75, 78 & 93 of 127.

Decision rationale: The Expert Reviewer based his/her decision on the MTUS Chronic Pain Medical Treatment Guidelines, pages 74-75, 78 & 93. The Expert Reviewer's decision rationale: As outlined in the MTUS, there is support for short acting opioids in the short-term management of moderate to severe breakthrough pain. However, when noting the 2 separate professional passes were employed, this medication was used nearly around-the-clock, and there was no clear clinical indication that there was any improvement, amelioration of the pain symptomatology, or functional improvement. There was no data presented to suggest that there was any efficacy whatsoever with this medication protocol. Therefore, based on the clinical information presented for review, there was no clear clinical indication for the continued medical necessity as a preparation. It was noted that there were pain complaints, but it does not appear that this medication was achieving its intended goal. Therefore, the request is not medically necessary.

Zolpidem 10 mg #30: 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), Treatment Index, 12th Edition (web), Pain (updated 5/15/14), Insomnia treatment, Zolpidem.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Pain chapter, updated September 2014.

Decision rationale: The Expert Reviewer based his/her decision on the Non-MTUS Pain chapter, updated September 2014. The Expert Reviewer's decision rationale: This medication is not addressed in either the MTUS and ACOEM guidelines. As noted in the ODG, this is a short

acting, non-benzodiazepine hypnotic, which is approved for the short-term (up to 6 weeks) treatment of sleep issues. It is clearly understood that proper sleep hygiene is a necessary component of chronic pain management. However, there is no narrative presented that there is any efficacy or utility in terms of increased sleep with this medication. Furthermore, this is not indicated for a chronic, constant or indefinite utilization. Therefore, based on the progress notes presented for review, the ongoing medical necessity for this medication has not been established.

Hydromorphone 8 mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 75, 78, 86.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009 Page(s): Page 74 of 127.

Decision rationale: The Expert Reviewer based his/her decision on the MTUS Chronic Pain Medical Treatment Guidelines, page 74. The Expert Reviewer's decision rationale: This said release opioid formulation is for the management of moderate to severe opioid tolerant patients requiring continuous around-the-clock opioid analgesia and is supported in the MTUS. However, there are 2 separate requests for 2 separate applications of fentanyl patches in addition to oral medications. Even with all of this amount of narcotic medication, there is no data presented to suggest there is any pain symptomatology or increase in the overall functionality. As such, the efficacy or utility of this medication has not been established. Accordingly, based on the progress notes presented for review, there was no medical necessity established for the continuation of this medication. It was noted that there were pain complaints; however, the efficacy of this medication has not been objectified. Therefore, the request is not medically necessary.