MAXIMUS Federal Services

Case Number:	CM14-0095516		
Date Assigned:	07/25/2014	Date of Injury:	10/20/1999
Decision Date:	09/09/2014	UR Denial Date:	06/11/2014
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 & Rehabilitation, and is licensed to practice in California. 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 61-year-old male who reported an injury on 10/20/1999 due to an unspecified mechanism of injury. On 03/26/2014, the injured worker reported that when it rained his pain would get aggravated; however, medications somewhat controlled his pain. An examination of the lumbar spine revealed tenderness noted on both sides of a surgical scar, intact sensation, +1 deep tendon reflexes bilaterally with knee and ankle jerks, and a positive straight leg raise on the left laying down at 45 degrees. Range of motion was documented as extension to 10/30 degrees, right and left lateral flexion to 25/35 degrees, and right and left lateral rotation to 35/45 degrees, it was also noted that the injured worker could go slightly below the knee area and after that was painful. His medications included Ambien 75 mg 1 by mouth at bedtime, Celexa 20 mg 1 by mouth daily, Percocet 10/325 mg 1 by mouth q 8 hours and a Duragesic patch 15 mcg per hour 1 every 48 hours. His diagnoses included status post lumbar spine surgery at the L4 through L5, and a lumbar sprain. Surgery included a lumbar spine surgery at the L4 through L5 performed on an unspecified date. Past treatments included surgery and medications. Information regarding diagnostic studies was not provided for review. The treatment plan was for a Duragesic patch 50 mcg #15, Percocet 10/325 mg #90, Celexa 20 mg #90, Ambien 5 mg #45. The Request for Authorization Form was signed on 03/26/2014. The rationale for treatment was not provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

Duragesic Patch 50mcg #15: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Duragesic Page(s): 44.

Decision rationale: The request for a Duragesic patch 50 mcg #15 isnot medically necessary. On 03/26/2014, the injured worker was noted to have pain that was aggravated when it rained. He stated that medication somewhat controlled his pain. It was noted that he was also taking multiple pain medications to address his pain. The California MTUS Guidelines state that Duragesic transdermal systems are not recommended as a first line therapy. It is indicated in the management of chronic pain in patients who require continuous opioid analgesia for pain that cannot be managed by other means. Based on the clinical information submitted for review, the injured worker was noted to be taking multiple pain medications in addition to the Duragesic patches. The use of a Duragesic patch in addition to multiple pain medications is unclear as the injured worker did not state that the other pain medications were not helping his symptoms. In addition, it appears as though the injured worker had been utilizing this medication for an extended period of time and there was no documentation showing evidence of efficacy of the medication. Furthermore, the requesting physician failed to provide the frequency of the medication within the request. In the absence of this information, the request would not be supported by the evidence-based guidelines. Given the above, the request is not medically necessary.

Percocet 10/325mg #90: Upheld

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

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

Decision rationale: The request for Percocet 10/325 mg #90 is not medically necessary. It was noted that the injured worker had been utilizing Percocet for an extended period of time to address his pain. The injured worker had stated that pain medications somewhat controlled his pain. The California MTUS Guidelines state that ongoing review and documentation of pain relief, functional status, and appropriate medication use and side effects should be performed during opioid therapy. Pain assessments should include current pain, the least reported pain over the period since last assessment, average pain, and intensity of pain after taking the opioid, how long it takes for pain relief, and how long pain relief lasts. There is lack of documentation regarding an ongoing review of pain relief, functional status, appropriate medication use and side effects of the medications. In addition, a proper pain assessment was not performed to prove that the injured worker had had a satisfactory response to the medication. Furthermore, the requesting physician failed to provide the frequency of the medication within the request. In the absence of this information, the request cannot be supported by the evidence-based guidelines. Given the above, the request is not medically necessary.

Celexa 20mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines SSRIs Page(s): 107.

Decision rationale: The request for Celexa 20 mg #90 is not medically necessary. It was noted within the documentation that the injured worker had stated that his pain would be aggravated by the rain. The California MTUS Guidelines state that SSRIs such as Celexa are not recommended as a treatment for chronic pain, but may have a role in treating secondary depression. Based on the clinical information submitted for review, the request for Celexa would not be medically necessary. The injured worker was not noted to have depression, and there was no documentation regarding objective functional improvement with the use of this medication to determine efficacy of its use for the injured worker's chronic pain symptoms. In addition, the use of this medication in addition to the other pain medications that the injured worker was utilizing is unclear. Furthermore, the requesting physician failed to provide the frequency within the request. In the absence of this information, the request would not be supported by the evidence-based guidelines. As such, the request is not medically necessary.

Ambien 5mg #45: Upheld

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

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

Decision rationale: The request for Ambien 5 mg #45 is not medically necessary. Per the note dated 03/26/2014, the injured worker had stated that his pain would be aggravated when it would rain. The California MTUS/ACOEM Guidelines do not address the medication Ambien. The Official Disability Guidelines state that Ambien is a prescription short-acting non-benzodiazepines hypnotic that is approved for short term treatment of insomnia. Based on the clinical information submitted for review, the use of this medication is not medically necessary. The injured worker was not noted to have insomnia and the rationale for the use of this medication is unclear. In addition, it is unclear how long the injured worker had been using this medication. Without knowing the exact length of treatment with this medication, continued use would not be supported as it is not recommended for a long term treatment option. Furthermore, the requesting physician did not provide the frequency of the medication within the request. In the absence of this information, the request would not be supported by the guideline recommendations. Given the above, the request is not medically necessary.