

Case Number:	CM14-0210058		
Date Assigned:	12/23/2014	Date of Injury:	04/20/2001
Decision Date:	03/16/2015	UR Denial Date:	11/25/2014
Priority:	Standard	Application Received:	12/15/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

Patient is a 48 year-old male with date of injury 04/20/2001. The medical document associated with the request for authorization, a primary treating physician's progress report, dated 11/04/2014, lists subjective complaints as pain in the low back. Patient is status post anterior-posterior fusion at L4-5 and L5-S1, and is status post removal of hardware and exploration of fusion on 05/06/2004. Objective findings: Examination of the lumbar spine revealed diminished reflexes in both legs. Positive straight leg raise on the left. Increased low back pain with straight leg raise on the right. Diagnosis: 1. Status post anterior-posterior fusion, L4-5 and L5-S1 2. Status post removal of hardware and exploration of fusion 3. Transitional S1-S2 4. Left shoulder impingement. Original reviewer modified medication request to Oxycontin 80mg, #45 and Oxycontin 40mg, #45. The medical records supplied for review document that the patient has been taking the following medication since at least as far back as six months. Medication: 1. Lidoderm 5% Patch (700mg/patch), #90 SIG: 3 to affected area q 12h out of 24h. 2. Oxycontin 80mg, #90 SIG: 1 po q 8h. 3. Oxycontin 40mg, #90 SIG: 1 po q 8h.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lidoderm 5% patch (700mg/patch) #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 56.

Decision rationale: Lidoderm is the brand name for a lidocaine patch produced by [REDACTED]. Topical lidocaine may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). This is not a first-line treatment and is only FDA approved for post-herpetic neuralgia. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than post-herpetic neuralgia. The patient does not suffer from post-herpetic neuralgia or localized peripheral pain. Lidoderm 5% patch (700mg/patch) #90 is not medically necessary.

Oxycontin 80mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-94.

Decision rationale: A previous utilization review decision provided the patient with sufficient quantity of medication to be weaned slowly off of narcotic. The Chronic Pain Medical Treatment Guidelines state that continued or long-term use of opioids should be based on documented pain relief and functional improvement or improved quality of life. Despite the long-term use of OxyContin, the patient has reported very little, if any, functional improvement or pain relief over the course of the last 6 months. Oxycontin 80mg #90 is not medically necessary.

Oxycontin 40mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-94.

Decision rationale: As stated above, a previous utilization review decision provided the patient with sufficient quantity of medication to be weaned slowly off of narcotic. The Chronic Pain Medical Treatment Guidelines state that continued or long-term use of opioids should be based on documented pain relief and functional improvement or improved quality of life. Despite the long-term use of OxyContin, the patient has reported very little, if any, functional improvement or pain relief over the course of the last 6 months. Oxycontin 40mg #90 is not medically necessary.

Urine drug screen: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Drug testing Page(s): 43.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Drug testing Page(s): 43.

Decision rationale: The MTUS recommends using a urine drug screen to assess for the use or the presence of illegal drugs, a step to take before a therapeutic trial of opioids, to aid in the ongoing management of opioids, or to detect dependence and addiction. There is no documentation in the medical record that a urine drug screen was to be used for any of the above indications. Urine drug screen is not medically necessary.