

Case Number:	CM15-0008764		
Date Assigned:	01/26/2015	Date of Injury:	07/18/2000
Decision Date:	03/26/2015	UR Denial Date:	12/12/2014
Priority:	Standard	Application Received:	01/15/2015

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, Arizona
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 59 year old male, who sustained an industrial injury on July 18, 2000. The diagnoses have included right lumbar facet pain, right L5 radiculopathy and post radiofrequency right piriformis syndrome. Treatment to date has included Magnetic resonance imaging of lumbar spine, right Piriformis and trochanteric bursa injections, radiofrequency ablation, oral pain medication and topical analgesics. On 12/02/2014, the injured worker presented with complaints of right hip pain, right leg pain, neck pain, and low back pain. The injured worker reported an improvement in symptoms following a piriformis injection. The injured worker also reported improvement following a radiofrequency ablation. Upon examination, there was normal cervical range of motion with minor stiffness, improved lumbar range of motion, improved tenderness over the right piriformis muscle, improved flexibility with flexion and internal rotation of the right hip, 5/5 motor strength, and intact sensation. Recommendations at that time included continuation of the current medication regimen of oxycodone 10/325 mg, testosterone 50 mg, and Voltaren 1% gel. A Request for Authorization form was submitted on 12/04/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Oxycodone - Acetaminophen 10/325mg, #240: 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): 74-82.

Decision rationale: The California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of nonopioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. The injured worker has continuously utilized the above medication since 2013. There is no documentation of objective functional improvement. Previous urine toxicology reports documenting evidence of patient compliance and nonaberrant behavior were not provided. Additionally, there is no frequency listed in the request. Given the above, the request is not medically appropriate.

Testosterone 50mg, #150: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 110.

Decision rationale: The California MTUS Guidelines recommend testosterone replacement in limited circumstances for patients taking high dose, long term opioids with documented low testosterone levels. Although it is noted that the injured worker has utilized long term opioids, there was no documentation of low testosterone levels. The injured worker has utilized the above medication since 2013. There is no evidence of any recent laboratory testing. There is also no frequency listed in the request. Given the above, the request is not medically appropriate.

Voltaren Gel 1% 300mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

Decision rationale: The California MTUS Guidelines state the only FDA-approved topical NSAID is diclofenac, which is indicated for the relief of osteoarthritis pain. It has not been approved for use in the spine, hip, or shoulder. Given the above, the request is not medically appropriate in this case.