

Case Number:	CM15-0105458		
Date Assigned:	06/09/2015	Date of Injury:	05/03/2002
Decision Date:	07/10/2015	UR Denial Date:	05/12/2015
Priority:	Standard	Application Received:	06/01/2015

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: Maryland

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

The injured worker is a 50 year old male who sustained an industrial injury on 5/3/12 when he was on a ladder and a 250 pound roll of wire came back on him and he felt cracks in his lumbar spine. He had fractures at L2, 3, 4, 5. He underwent 5 surgical interventions, physical therapy and pain management. He currently complains of returning lower extremity pain (6-7/10); moderate to severe lumbar spine pain radiating to bilateral lower extremities; sacroiliac pain with positive Forth Finger Test, Jump sign and Gaenslen's. In addition, he complains of new onset of left upper extremity pain and neck pain with numbness and tingling of the hand and thumb. He has sleep disturbances. Diagnoses include status post lumbar spine surgery #6 (10/3/12); post laminectomy fusion syndrome; failed back surgery X5 interventions; mechanical dysfunction of thoraco-lumbar spine, post fusion; sacroiliac joint pain; lumbar neuralgia; arachnoiditis; opioid dependence. Treatments to date include L5 transforaminal epidural injection (12/30/14) with 50% relief of lower extremity pain; injection (5/7/15) for sacroiliac pain; lumbar brace. Diagnostics include MRI of the cervical spine (no date) showing neural impingement; MRI lumbar spine (3/14/11) with evidence of Arachnoiditis. In the progress note dated 5/7/15 the treating provider's plan of care includes requests to continue oxycontin, Androgel and Restoril.

IMR ISSUES, DECISIONS AND RATIONALES

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

Oxycontin 80mg #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Ongoing management Page(s): 78-80.

Decision rationale: Oxycontin 80mg #120 is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The MTUS states that a satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. The MTUS does not support ongoing opioid use without improvement in function or pain. The documentation reveals that the patient has been on long term opioids without significant evidence of functional improvement therefore the request for continued Oxycontin is not medically necessary.

Androgel 1.62%, 2 pumps daily: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Testosterone replacement for hypogonadism (related to opioids) Page(s): 110.

Decision rationale: Androgel 1.62%, 2 pumps daily is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. Testosterone replacement for hypogonadism (related to opioids) is recommended in limited circumstances by the MTUS for patients taking high-dose long-term opioids with documented low testosterone levels. The documentation does not reveal evidence of low testosterone therefore this request is not medically necessary.

Restoril 30mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

Decision rationale: Restoril 30mg #60 is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The guidelines state that benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. Their range of action includes sedative/hypnotic, anxiolytic, anticonvulsant, and muscle relaxant. Tolerance to anticonvulsant and muscle relaxant effects occurs within weeks. The documentation indicates that the patient has been on Restoril. The documentation does not indicate extenuating circumstances which would necessitate going against guideline recommendations and using this medication long term. The request for Restoril is not medically necessary.