

Case Number:	CM15-0015921		
Date Assigned:	02/03/2015	Date of Injury:	08/29/2000
Decision Date:	05/19/2015	UR Denial Date:	01/15/2015
Priority:	Standard	Application Received:	01/27/2015

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
 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 57 year old, who sustained an industrial injury on 08/29/2000. The mechanism of injury was not provided. Diagnoses include degenerative disc disease of the lumbar spine and status post lumbar facet radiofrequency ablation to L3-S1. Treatments to date include surgery, physical therapy and medication management. A progress note from the treating provider dated 1/8/2015 indicates the injured worker reported low back, buttock and leg pain. The current medication regimen includes Oxycontin 40 mg, Roxicodone 30 mg, Provigil 200 mg, trazodone 50 mg, Flexeril 10 mg, Wellbutrin 300 mg and Lidoderm 5% patch. The provider indicated that the injured worker was stable on the current medication regimen. Upon examination there was significant muscle spasm bilaterally from L1 to the sacrum, pain with manipulation of the lumbar spine in all planes, and antalgic gait, moderate to severe sacroiliitis, left trochanteric bursitis, normal deep tendon reflexes, and hypersensitivity. There was also dysesthesia noted in the bilateral lower extremities. Recommendations at that time included continuation of the current medication regimen. A Request For Authorization form was then submitted on 01/08/2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

Roxicodone 30mg QTY 240.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 76-80.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

Decision rationale: 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 at least 09/2014. Although, the provider documented an improvement in symptoms with the current medication regimen, there was no objective evidence of functional improvement. The injured worker continues to present with persistent low back, buttock and leg pain. Physical examination continues to reveal pain with manipulation of the lumbar spine, significant muscle spasm, moderate to severe sacroiliitis, and hypersensitivity. In addition, there was no frequency listed in the request. As such, the request is not medically appropriate.

Lidoderm 5% Patches #90 + 2 refills QTY:270.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm (lidocaine patch).

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

Decision rationale: California MTUS Guidelines state lidocaine is indicated for neuropathic pain or localized peripheral pain after there has been evidence of a trial of first line therapy with tricyclic or SSRI antidepressants or an anticonvulsant. In this case, there was documentation of a failure to respond to first line treatment. The injured worker has utilized the above medication since at least 09/2014. There is no documentation of objective functional improvement. There is also no frequency listed in the request. Given the above, the request is not medically appropriate.

Provigil 200 mg #30 + 2 refills QTY:90.00: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Pain, Modafinil (Provigil).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter, Provigil; ½ (modafinil).

Decision rationale: The Official Disability Guidelines state that Provigil is the brand name for modafinil which is approved by the FDA for the treatment of narcolepsy. Prescribers using

Provigil for sedation effects of opiates should consider reducing the dose of opiates before adding a stimulant. In this case, it is noted that the injured worker has continuously utilized Provigil 200 mg since at least 09/2014. There is no indication that this provider has attempted to reduce the intake of opiates prior to adding Provigil. There is also no mention in the current medical records of the benefit provided to the injured worker. There is also no frequency listed in the request. Given the above, the request is not medically appropriate at this time.

Flexeril 10mg #90 + 2 refills QTY:270.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 64-66.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63-66.

Decision rationale: California MTUS Guidelines state that muscle relaxants are recommended as a non-sedating second line options for short term treatment of acute exacerbations. Cyclobenzaprine should not be used for longer than 2 to 3 weeks. In this case, the injured worker has utilized the above medication since at least 09/2014. Despite the ongoing use of this medication there is evidence of significant muscle spasm from L1 to the sacrum upon examination. Guidelines do not support long term use of this medication. There is also no frequency listed in the request. Given the above, the request is not medically appropriate at this time.