

Case Number:	CM15-0188076		
Date Assigned:	09/30/2015	Date of Injury:	10/20/1999
Decision Date:	12/04/2015	UR Denial Date:	08/24/2015
Priority:	Standard	Application Received:	09/24/2015

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, Pain Management

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 62 year old male, who sustained an industrial injury on October 20, 1999. The initial symptoms reported by the injured worker are unknown. The injured worker was currently diagnosed as status post lumbar spine surgery at L4-L5 and lumbar sprain. Treatment to date has included medication and exercise. On July 1, 2015, the injured worker complained of low back pain with radiation to his left leg and left foot with numbness and tingling. He rated the pain as a 10 on a 0-10 pain scale. With medication, his pain was noted to go down to a 0-1 on the pain scale. On August 5, 2015, the injured worker complained of back spasms. Physical examination revealed severe tenderness at L4-L5. Regarding range of motion, he could barely flex to 50-60%. Straight leg raising was positive at 45 degrees from laying down flat on the left side. The treatment plan included Duragesic patch, Percocet, Ambien, deep tissue massage, continuation of home exercises and a follow-up visit as needed. On August 24, 2015, utilization review denied a request for Duragesic patch 50mcg #15, Percocet 10-325mg #120, Ambien 10mg #30 and deep tissue massage two times a week for three weeks.

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 Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Duragesic (fentanyl transdermal system), Fentanyl, Opioids (Classification), Opioids, California Controlled Substance Utilization Review and Evaluation System (CURES) [DWC], Opioids, criteria for use, Opioids for chronic pain.

Decision rationale: Regarding the request for Duragesic (Fentanyl), Chronic Pain Medical Treatment Guidelines state that Fentanyl is an opiate pain medication. Due to high abuse potential, close follow-up is recommended with documentation of analgesic effect, objective functional improvement, side effects, and discussion regarding any aberrant use. Guidelines go on to recommend discontinuing opioids if there is no documentation of improved function and pain. Regarding the use of Fentanyl, guidelines state that it should be reserved for use as a second-line opiate. Within the documentation available for review, there is indication that the medication is improving the patient's pain. However, there is no documentation regarding specific examples of functional improvement, and no documentation regarding side effects. As such, there is no clear indication for ongoing use of the medication. Opioids should not be abruptly discontinued, but unfortunately, there is no provision to modify the current request to allow tapering. In light of the above issues, the currently requested Duragesic (Fentanyl), is not medically necessary.

Percocet 10/325mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids (Classification), Opioids, California Controlled Substance Utilization Review and Evaluation System (CURES) [DWC], Opioids, criteria for use, Opioids for chronic pain.

Decision rationale: Regarding the request for Percocet (Oxycodone/acetaminophen), Chronic Pain Medical Treatment Guidelines state that Percocet is an opiate pain medication. Due to high abuse potential, close follow-up is recommended with documentation of analgesic effect, objective functional improvement, side effects, and discussion regarding any aberrant use. Guidelines go on to recommend discontinuing opioids if there is no documentation of improved function and pain. Within the documentation available for review, there is indication that the medication is improving the patient's pain. However, there is no documentation regarding specific examples of functional improvement, and no documentation regarding side effects. As such, there is no clear indication for ongoing use of the medication. Opioids should not be abruptly discontinued, but unfortunately, there is no provision to modify the current request to allow tapering. In light of the above issues, the currently requested Percocet (Oxycodone/acetaminophen) is not medically necessary.

Ambien 10mg #30: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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 & Mental Illness and Stress Chapter, Insomnia Topics.

Decision rationale: Regarding the request for Ambien, California MTUS guidelines are silent regarding the use of sedative hypnotic agents. ODG recommends the short-term use (usually two to six weeks) of pharmacological agents only after careful evaluation of potential causes of sleep disturbance. They go on to state the failure of sleep disturbances to resolve in 7 to 10 days, may indicate a psychiatric or medical illness. Within the documentation available for review, there are no subjective complaints of insomnia in recent progress notes. In addition, there appears to be a longer term use of Ambien in excess of guideline recommendations of 6 weeks. Given this, the currently requested Ambien is not medically necessary.

Deep tissue massage 2 times a week for 3 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back (Acute & Chronic).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Massage therapy.

Decision rationale: Regarding the request for massage therapy, Chronic Pain Medical Treatment Guidelines state the massage therapy is recommended as an option. They go on to state the treatment should be an adjunct to other recommended treatment (e.g. exercise), and it should be limited to 4 to 6 visits in most cases. Within the documentation available for review, there is no indication as to the number of massage therapy visits the patient has previously undergone. Furthermore, there is no documentation of objective functional improvement from the therapy sessions already authorized. Additionally, there is no indication that the currently requested massage therapy will be used as an adjunct to other recommended treatment modalities. In the absence of clarity regarding those issues, the currently requested massage therapy is not medically necessary.