MAXIMUS Federal Services

Case Number:	CM15-0043080		
Date Assigned:	03/13/2015	Date of Injury:	04/19/1990
Decision Date:	11/10/2015	UR Denial Date:	02/03/2015
Priority:	Standard	Application Received:	03/06/2015

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: 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:

The injured worker is a 57 year old female who sustained an industrial injury on 04/19/90. A review of the medical records indicates the injured worker is undergoing treatment for severe complex regional pain syndrome lower extremities, failed back syndrome, bilateral shoulder pain, bilateral lower leg infection. Medical records (02-03-15) reveal the injured worker is oxygen dependent, with a Foley catheter, and is considered to be immobile. The physical exam (02003015) reveals bilateral paravertebral muscle tenderness, midline tenderness in the lumbar spine, bilateral lumbar and sacroiliac joint tenderness, bilateral shoulder tenderness, left intercostal area tenderness, and increase sensitivity in the lower legs. There is no documented pain rating. Treatment has included trial dorsal column stimulator with removal, implantation of 2 pain pumps and removal of one, multiple back surgeries, medications, acute respiratory failure, urinary tract infection with sepsis, malnutrition, hyponatremia and multiple bilateral lower extremity wound debridements and procedures. The treating provider indicates the injured worker requires 2 nurses' aides day and night and an additional aide on an as-needed basis. The original utilization review (02-03-15) noncertified the request for an unknown number of Compazine 10 mg tabs and Lidoderm patches, as well as OxyContin 80 mg #360 and a refill of the SynchroMed pump.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 prescription of Oxycontin 80mg #360: 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 for chronic pain.

Decision rationale: 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. The examination findings provided no objective or quantitative measure of pain to determine severity. 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. A previous utilization review decision provided the patient with sufficient quantity of medication to be weaned slowly off of narcotic. 1 prescription of Oxycontin 80mg #360 is not medically necessary.

1 prescription of Compazine 10mg: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), Antiemetics (for opioid nausea).

Decision rationale: Prochlorperazine oral (Compazine) is used to treat psychotic disorders such as schizophrenia. It is also used to treat anxiety, and to control severe nausea and vomiting. The Official Disability Guidelines state that Compazine is not recommended for nausea and vomiting secondary to chronic opioid use and there is no documentation of schizophrenia. One prescription of Compazine 10mg is not medically necessary.

1 prescription of Lidoderm patch #30: 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): Lidoderm (lidocaine patch).

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. 1 prescription of Lidoderm patch #30 is not medically necessary.

1 refill of SynchroMed pump: 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): Implantable drug-delivery systems (IDDSs).

Decision rationale: According to the MTUS, there are numerous criteria which must be met prior to consideration of an implantable drug-delivery system. There is documentation that the patient has fulfilled a number of the criteria, and the IDDS is implanted. A refill was authorized by the previous utilization review physician in a prior request contained within the current RFA. An additional authorization is repetitive and unnecessary. One refill of SynchroMed pump is not medically necessary.