MAXIMUS Federal Services

Case Number:	CM15-0059043		
Date Assigned:	04/03/2015	Date of Injury:	12/31/1990
Decision Date:	05/22/2015	UR Denial Date:	03/13/2015
Priority:	Standard	Application Received:	03/27/2015

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: Family Practice

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 54-year-old male who reported an injury on 12/31/1990. The mechanism of injury was not specifically stated. The current diagnoses include chronic back pain, lumbar degenerative disc disease, lumbar postlaminectomy syndrome, and right iliac crest donor site pain. The injured worker presented on 03/19/2015 for a follow-up evaluation with complaints of 4/10 low back pain. The injured worker also reported poor sleep quality. There was no change in the activity level. The current medication regimen includes Zanaflex, Voltaren 1% gel, Duragesic, fentanyl, Percocet, Restoril, and Adderall. Upon examination of the lumbar spine, there was a loss of normal lordosis with straightening of the lumbar spine, restricted range of motion with flexion to 57 degrees, extension to 12 degrees, tenderness to palpation over the paravertebral muscles, positive lumbar facet loading on the right, and negative straight leg raise. There was tenderness noted over the right iliac crest donor site. Motor testing was within normal limits. Sensation was intact to light touch and deep stimulation. Treatment recommendations at that time included continuation of the current medication regimen. An additional referral for inpatient detoxification was recommended, as well as a referral to a weight management specialist. The provider indicated the injured worker had failed to respond to conservative modalities, including diet and exercise. The Request for Authorization form was then submitted on 03/19/2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

Referral to In-Patient Detox Program: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Weaning of Medications. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain (Chronic), Hospital length of stay (LOS), Rapid detox, Detoxification.

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, Detoxification.

Decision rationale: According to the Official Disability Guidelines, detoxification is most commonly recommended when there is evidence of substance misuse or abuse, evidence that medication is not efficacious, or evidence of excessive complication related to use. The hospital length of stay for inpatient drug detoxification includes a median of 4 days. The request as submitted failed to indicate the specific duration of treatment. There is no indication that this injured worker has attempted a gradual weaning of medication prior to the request for an inpatient detoxification. Given the above, the request is not medically necessary.

Referral to a Weight Management Specialist for Evaluation and Unknown Treatment: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Pharmacologic and surgical management of obesity in primary care: a clinical practice guideline from the American College of Physicians. Ann Intern Med 2005 Apr 5; 142(7): 525-31.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 7.

Decision rationale: California MTUS Guidelines state functional restoration is an established treatment approach that aims to minimize the residual complaints and disability resulting from acute and/or chronic medical conditions. Independent self-management is the long-term goal of all forms of functional restoration. The principles of functional restoration apply to all conditions in general, and are not limited to injuries or pain. As per the clinical documentation submitted, there is no evidence of any comorbid factors such as hypertension, Diabetes Mellitus, or obstructive sleep apnea. There is no indication that the injured worker has been referred for surgical intervention. The medical necessity for the requested service has not been established. Therefore, the request is not medically appropriate.

Duragesic 12mcg/hr patch #15 with 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Duragesic (fentanyl transdermal system), Opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 44.

Decision rationale: California MTUS Guidelines do not recommend fentanyl transdermal system as a first line therapy. It is indicated in the management of chronic pain in patients who require continuous opioid analgesia for pain that cannot be managed by other means. In this case, the injured worker has utilized the above medication since at least 08/2014. There is no documentation of objective functional improvement despite the ongoing use of this medication. The injured worker continues to report persistent pain with poor sleep quality. There is also no frequency listed in the request. As such, the request is not medically appropriate.

Fentanyl 25mcg/hr patch #15 with 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Duragesic (fentanyl transdermal system), Opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 44.

Decision rationale: California MTUS Guidelines do not recommend fentanyl transdermal system as a first line therapy. It is indicated in the management of chronic pain in patients who require continuous opioid analgesia for pain that cannot be managed by other means. In this case, the injured worker has utilized the above medication since at least 08/2014. There is no documentation of objective functional improvement despite the ongoing use of this medication. The injured worker continues to report persistent pain with poor sleep quality. There is also no frequency listed in the request. As such, the request is not medically appropriate.

Percocet 10-325mg #90 with 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Oxycodone/Acetaminophen, Opioids, Weaning of Medications.

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 nonopiod 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 08/2014. Despite the ongoing use of this medication, the injured worker continues to report persistent pain with poor sleep quality. There is no documentation of objective functional improvement. Recent urine toxicology reports documenting evidence of injured worker compliance and nonaberrant behavior were not provided. There is also no frequency listed in the request. As such, the request is not medically necessary.

Restoril 30mg #15 with 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain (Acute & Chronic), Insomnia Treatment.

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

Decision rationale: California MTUS Guidelines do not recommend long term use of benzodiazepines because long term efficacy is unproven and there is a risk of dependence. The injured worker has utilized the above medication since at least 08/2014. There is no mention of functional improvement as a result of the ongoing use of this medication. Guidelines would not support long term use of this medication. There is also no frequency listed in the request. As such, the request is not medically necessary.