MAXIMUS Federal Services

Case Number:	CM15-0084179		
Date Assigned:	05/06/2015	Date of Injury:	06/04/1993
Decision Date:	07/01/2015	UR Denial Date:	04/03/2015
Priority:	Standard	Application Received:	05/01/2015

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: 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 50 year old male, who sustained an industrial injury on 06/04/1993. Medical records provided by the treating physician did not indicate the injured worker's mechanism of injury. The injured worker was diagnosed as having lumbar degenerative disc disease, status post lumbar/sacral spinal fusion, lumbar radiculopathy to the right lower extremity, cervical degenerative disc disease, status post cervical fusion, cervical radiculopathy, and failed back surgery. Treatment to date has included placement of a spinal stimulator, acupuncture, biofeedback, chiropractic therapy, and medication regimen. In a progress note dated 03/18/2015 the treating physician reports complaints of neck, low back, and right lower extremity pain. The pain to the neck is noted to radiate to the right shoulder and arm and the pain to the low back is noted to radiate to the right leg. The pain in the neck and arm is described as constant and shooting and the pain in the low back and right lower extremity is described as aching. The injured worker's current pain is rated 4 out of 10, at rest a 2 out of 10, and with activity a 7 out of 10. The pain is noted to improve with rest and medications and worsens with walking and standing. While the documentation indicates the injured worker's pain improves with medication, the medical records lacked documentation of any functional improvement or a level of pain on a pain scale secondary to medication regimen. Associated symptoms noted are weakness and numbness to the right lower extremity and spasms to the upper back. The treating physician requested the medications of Fentanyl Citrate 800 mcg with a quantity of 600, Oxycodone compound 70 mg with a quantity of 150, Tizanidine 4 mg with a quantity of 90, and

Fentanyl patch 50 mcg with a quantity of 10 noting that the injured worker is currently on these medications, but did not indicate the specific reason for these requested medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

Fentanyl Cit 800 mcg #600: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Fentanyl transdermal CRITERIA FOR USE OF OPIOIDS Page(s): 93, 76-78, 88-89.

Decision rationale: The patient was injured on 06/04/93 and presents with pain in his low back, neck, and right lower extremity. The request is for FENTANYL CIT 800 MCG #600. The RFA is dated 03/26/15 and the patient is retired. There are two reports provided from 09/17/14 and 03/18/15. Reports provided are hand-written and partially illegible. MTUS Guidelines page 93 regarding Fentanyl transdermal states, "indicated for management of persistent chronic pain, which is moderate to severe requiring continuous, around the clock opiate therapy. The pain cannot be managed by other means (e.g., NSAIDs)." MTUS Guidelines pages 88 and 89 states, "pain should be assessed at each visit and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4 A's (analgesia, ADLs, adverse side effects, and adverse behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work, and duration of pain relief. The patient is diagnosed with lumbar degenerative disc disease, status post lumbar/sacral spinal fusion, lumbar radiculopathy to the right lower extremity, cervical degenerative disc disease, status post cervical fusion, cervical radiculopathy, and failed back surgery. Treatment to date has included placement of a spinal stimulator, acupuncture, biofeedback, chiropractic therapy, and medication regimen. In this case, none of the 4 A's are addressed as required by MTUS Guidelines. The treater does not provide any before-and-after pain scales. There are no examples of ADLs which demonstrate medication efficacy, nor are there any discussions provided on adverse behavior/side effects. No validated instruments are used either. There is no pain management issues discussed such as urine drug screens, CURES report, pain contract, etc. No outcome measures are provided as required by MTUS Guidelines. The treating physician does not provide proper documentation that is required by MTUS Guidelines for continued opiate use. Therefore, the requested Fentanyl Cit IS NOT medically necessary.

Oxycodone 70mg cmpd #150: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CRITERIA FOR USE OF OPIOIDS Page(s): 76-78, 88-89.

Decision rationale: The patient was injured on 06/04/93 and presents with pain in his low back, neck, and right lower extremity. The request is for OXYCODONE 70 MG CMPD #150. The RFA is dated 03/26/15 and the patient is retired. It is unknown when the patient began taking this medication. There are two reports provided from 09/17/14 and 03/18/15. It is unknown when the patient began taking this medication. Reports provided are hand-written and partially illegible. MTUS Guidelines pages 88 and 89 states, "pain should be assessed at each visit and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4 A's (analgesia, ADLs, adverse side effects, and adverse behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work, and duration of pain relief. The patient is diagnosed with lumbar degenerative disc disease, status post lumbar/sacral spinal fusion, lumbar radiculopathy to the right lower extremity, cervical degenerative disc disease, status post cervical fusion, cervical radiculopathy, and failed back surgery. Treatment to date has included placement of a spinal stimulator, acupuncture, biofeedback, chiropractic therapy, and medication regimen. In this case, none of the 4 A's are addressed as required by MTUS Guidelines. The treater does not provide any before-and-after pain scales. There are no examples of ADLs which demonstrate medication efficacy, nor are there any discussions provided on adverse behavior/side effects. No validated instruments are used either. There is no pain management issues discussed such as urine drug screens, CURES report, pain contract, etc. No outcome measures are provided as required by MTUS Guidelines. The treating physician does not provide proper documentation that is required by MTUS Guidelines for continued opiate use. Therefore, the requested Oxycodone IS NOT medically necessary.

Tizanidine 4mg #90: Upheld

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

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

Decision rationale: The patient was injured on 06/04/93 and presents with pain in his low back, neck, and right lower extremity. The request is for TIZANIDINE 4 MG #90. The RFA is dated 03/26/15 and the patient is retired. There are two reports provided from 09/17/14 and 03/18/15. It is unknown when the patient began taking this medication. Reports provided are hand-written and partially illegible. MTUS Guidelines pages 63 through 66 state "recommended non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbation in patients with chronic low back pain." They also state "This medication has been reported in case studies to be abused for euphoria and to have mood elevating effects." He has weakness/numbness in his right leg and spasms along his neck. Objective findings are illegible and unclear. The patient is diagnosed with lumbar degenerative disc disease, status post lumbar/sacral spinal fusion, lumbar radiculopathy to the right lower extremity, cervical degenerative disc disease, status post cervical fusion, cervical radiculopathy, and failed back surgery. Treatment to date has included placement of a spinal stimulator, acupuncture,

biofeedback, chiropractic therapy, and medication regimen. In this case, the treating physician does not document an improvement in function or a reduction in pain due to Tizanidine use. MTUS guidelines page 60 require recording of pain and function when medications are used for chronic pain. Therefore, the requested Tizanidine IS NOT medically necessary.