

Case Number:	CM14-0119523		
Date Assigned:	08/06/2014	Date of Injury:	12/11/2006
Decision Date:	10/10/2014	UR Denial Date:	07/18/2014
Priority:	Standard	Application Received:	07/29/2014

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. The expert reviewer is Board Certified in Physical Medicine & Rehabilitation and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 65-year-old male who reported an injury 12/11/2006. The mechanism of injury was the injured worker was hit on the head by a forklift on 12/11/2006. The clinical note dated 06/24/2014 indicated diagnoses of lumbar postsurgical syndrome, lumbar facet joint pain, sacroiliac joint pain, lumbar neuralgia, cervicalgia, cervical neuralgia, chronic pain syndrome and opioid dependence. It was noted he was stable on medication management. On physical examination of the lumbar spine, there were paravertebral muscle spasms and the injured worker's bilateral sacroiliac joint was mildly tender. The injured worker's lumbar range of motion was decreased with pain. The injured worker had a positive Kemp's sign. The injured worker's prior treatments included physical therapy, epidural injections, 2 spinal cord stimulator trials, surgery and medication management. The injured worker's treatment plan included a request for lumbar orthotic support and refills of medications. The injured worker's medication regimen included oxycodone, hydrocodone, and creams. The provider submitted a request for oxycodone, hydrocodone and topical creams. A Request for Authorization was not submitted for review to include the date the treatment was requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

Oxycodone 30 Mg #120: 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 Opioids, Criteria for Use, On-going Management, Page(s): 78.

Decision rationale: The California MTUS Guidelines recommend the use of opioids for the on-going management of chronic low back pain. The ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should be evident. It was noted the injured worker was stable on medication management. However, a complete pain assessment was not provided. There is a lack of significant evidence of an objective assessment of the injured worker's pain level, functional status, and evaluation of risk for aberrant drug use behaviors and side effects. Furthermore, the request does not indicate a frequency. Therefore, the request for Oxycodone 30 Mg #120 is not medically necessary.

Hydrocodone 10/325Mg #120: 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 Opioids, Criteria for Use, On-going Management, Page(s): 78.

Decision rationale: The California MTUS Guidelines recommend the use of opioids for the on-going management of chronic low back pain. The ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should be evident. The medical records provided indicate the injured worker was stable on medication management. However, a complete pain assessment was not provided. There is a lack of significant evidence of an objective assessment of the injured worker's pain level, functional status, and evaluation of risk for aberrant drug use behaviors and side effects. Furthermore, the request does not indicate a frequency. Therefore, the request request for Hydrocodone 10/325Mg #120 is not medically necessary.

Topical Creams 20% - 30 grams (Unspecified Kind, %): 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 Topical Analgesics Page(s): 111.

Decision rationale: The California MTUS guidelines indicate that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. It was not indicated that the injured worker had tried and failed antidepressants or anticonvulsants. The provider did not indicate a rationale for the request. Additionally, the request does not indicate the ingredients of

the topical cream requested. Furthermore, the request does not indicate a frequency, quantity, or site of application. Therefore, the request for Topical Creams 20% - 30 grams (Unspecified Kind, %) is not medically necessary.