MAXIMUS Federal Services

Case Number:	CM14-0144274		
Date Assigned:	09/12/2014	Date of Injury:	05/22/2008
Decision Date:	10/29/2014	UR Denial Date:	08/19/2014
Priority:	Standard	Application Received:	09/05/2014

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 Internal Medicine and is licensed to practice in New York. 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 claimant is a 40 y/o male who sustained an industrial injury on 05/22/2008. The mechanism of injury was not provided for review. His diagnoses include low back pain, lumbar radiculitis, lumbar herniated disc, and myofascial pain syndrome. He complains of constant low back pain described as aching and ongoing. Physical exam demonstrated tenderness over the lumbar spine and decreased range of motion. Treatment has included medical therapy with Oxycodone 30mg Q 4 hrs., Oxycontin 60mg Q 8 hrs., Zanaflex 6mg QHS, and Gabapentin 300mg tid, and epidural steroid injection therapy. The treating provider has requested Retro Oxycodone 30mg # 120, Retro Oxycontin 60mg # 90, Zanaflex 6mg # 30 with 3 refills, and Gabapentin 300mg #90 with 2 refills.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retro Oxycodone 30mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 91-97.

Decision rationale: The documentation indicates the enrollee has been treated with opioid therapy with Oxycodone. Per California MTUS Guidelines, short-acting opioids are seen as an effective method in controlling chronic pain. They are often used for intermittent or breakthrough pain. The treatment of chronic pain with any opioid agent requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include current pain: last reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid, and the duration of pain relief. Per the medical documentation, there has been no documentation of the medication's pain relief effectiveness and no clear documentation that he has responded to ongoing opioid therapy. According to the California MTUS Guidelines there has to be, certain criteria followed including an ongoing review and documentation of pain relief and functional status. This does not appear to have occurred with this patient. The patient has continued pain despite the continued use of short acting opioid medications. The patient may require a multidisciplinary evaluation to determine the best approach to treatment of his chronic pain syndrome. The requested treatment is not medically necessary.

Retro Oxycontin 60mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 91-97.

Decision rationale: The documentation indicates the enrollee has been treated with opioid therapy with Oxycontin 60 mg bid. In addition, Oxycodone for breakthrough pain. Per California MTUS Guidelines, Oxycontin is a long acting very potent analgesic that is usually combined with acetaminophen or Aspirin. Short-acting opioids are seen as an effective method in controlling chronic pain. They are often used for intermittent or breakthrough pain. The treatment of chronic pain with any opioid agent requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include current pain: last reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid, and the duration of pain relief. Per the medical documentation, there has been no documentation of the medication's pain relief effectiveness and no clear documentation that he has responded to ongoing opioid therapy. In addition his present narcotic regimen is at 450 MED which is in excess of the recommended 120 MED for chronic non-malignant pain. According to the California MTUS Guidelines there has to be, certain criteria followed including an ongoing review and documentation of pain relief and functional status. This does not appear to have occurred with this patient. The patient has continued pain despite the use of long and short acting opioid medications. The patient may require a multidisciplinary evaluation to determine the best approach to treatment of his chronic pain syndrome. The requested treatment is not medically necessary.

Retro Zanaflex 60mg #30 with 3 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antispasticity/Antispasmodic.

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

Decision rationale: Tizanidine (Zanaflex) is a centrally acting alpha-2-adrenergic agent FDA approved for the treatment of spasticity; unlabeled use for low back pain. It is indicated for the treatment of chronic myofascial pain and as adjunct treatment for the treatment of fibromyalgia. Per California MTUS Guidelines, muscle relaxants are not considered any more effective than nonsteroidal anti-inflammatory medications alone. The claimant has no reported lumbar spasm on exam. Medical necessity for the requested treatment has not been established. The requested treatment is not medically necessary.

Retro Gabapentin 300mg #90 with 2 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Epilepsy (AEDs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 13.

Decision rationale: The requested medication, Gabapentin is not medically necessary for the treatment of the patient's condition. Per the documentation, there is no evidence that the claimant has neuropathic pain. Per California MTUS Guidelines 2009 Antiepilepsy, medications are a first line treatment for neuropathic pain. A recommended trial period for an adequate trial of Gabapentin is three to eight weeks for titration, then one to two weeks at maximum tolerated dosage. The patient has been prescribed the medication and there is no specific documentation of a positive response to this medical therapy. Medical necessity has been documented and the requested treatment is medically necessary for treatment of the patient's chronic pain condition.