

Case Number:	CM15-0063565		
Date Assigned:	04/09/2015	Date of Injury:	05/03/2002
Decision Date:	06/10/2015	UR Denial Date:	03/23/2015
Priority:	Standard	Application Received:	04/03/2015

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: New York
 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 05/03/2002. The mechanism of injury involved a ladder. The injured worker was diagnosed as status post lumbar spine surgery, post laminectomy/fusion syndrome, failed back surgery x5, mechanical dysfunction of thoracolumbar spine, sacroiliac joint pain, lumbar neuralgia, arachnoiditis and opioids dependence. Treatment to date has included epidural steroid injection, oral medications including opioids, multiple spinal surgeries and physical therapy. The injured worker presented on 03/05/2015 for a follow-up evaluation with complaints of 7/10 pain. The injured worker also reported sleep disturbance and depressive symptoms. The injured worker was status post L3-S1 fusion. Upon examination, there was subjective weakness in the left lower extremity, positive straight leg raise on the left, positive Braggard's test on the left, positive Kemp's testing on the left, increased burning pain corresponding to the left L5 dermatome, asymmetric deep tendon reflexes, and 3+/5 motor weakness in the left lower extremity. Treatment recommendations at that time included continuation of the current medication regimen.

IMR ISSUES, DECISIONS AND RATIONALES

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

Naproxen 550mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 67-68, 73.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67-72.

Decision rationale: California MTUS Guidelines state NSAIDS are recommended for osteoarthritis at the lowest dose for the shortest period in patients with moderate to severe pain. For acute exacerbations of chronic pain, NSAIDS are recommended as a second line option after acetaminophen. The injured worker has utilized the above medications since 11/2014. There is no documentation of objective functional improvement. Guidelines do 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.

Oxycontin 80mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Weaning of Medications Page(s): 78-80, 92, 124.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

Decision rationale: California MTUS Guidelines state therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. In this case, the injured worker has utilized the above medications since 11/2014. There is no documentation of objective functional improvement. In addition, there is no frequency listed in the request. As such, the request is not medically necessary.

Neurontin 330mg #180: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs Page(s): 18-19.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 16-19.

Decision rationale: California MTUS Guidelines recommend gabapentin for neuropathic pain. The injured worker has utilized this medication since 11/2014 without any evidence of objective functional improvement. There is also no frequency listed in the request. As such, the request is not medically necessary.

Restoril 30mg #60: Upheld

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

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 11/2014. There is no mention of functional improvement as a result of the ongoing use of this medication. In addition, guidelines do not support long-term use of benzodiazepines. There is also no frequency listed in the request. As such, the request is not medically necessary.

Androgel 1.62%: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Testosterone replacement for hypogonadism (related to opioids) Page(s): 110-111.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 110.

Decision rationale: Androgel is a testosterone replacement medication. According to the California MTUS Guidelines, testosterone replacement is recommended in limited circumstances for patients taking high dose and long-term opioids with documented low testosterone levels. In this case, the injured worker does not meet criteria for the requested medication. In addition, the injured worker has utilized the above medication since 11/2014. There is no documentation of any recent laboratory studies to include a current testosterone level. There is also no frequency or quantity listed in the request. Given the above, the request is not medically necessary.