

Case Number:	CM13-0017606		
Date Assigned:	06/06/2014	Date of Injury:	03/15/2011
Decision Date:	07/11/2014	UR Denial Date:	07/01/2013
Priority:	Standard	Application Received:	08/28/2013

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 California, Kentucky, Colorado, and North Carolina. 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 45 year old male who sustained work related injuries to his low back on 03/15/11. The record did contain a mechanism of injury. However, as a result, the injured worker underwent L5-S1 fusion in 08/11. Post-operatively the records indicated no relief. Treatment included oral medications chiropractic and acupuncture. The claimant developed a pseudoarthrosis at L5-S1. He subsequently underwent EMG/NCV indicating a chronic left L5 radiculopathy. The injured worker continued to have low back pain radiating into the left lower extremity. He underwent a revision of the prior surgery on 10/10/13. Most recent physical examinations noted deep tendon reflexes were equal and symmetric at the knees and ankles. Motor strength was graded 5/5 in all muscle groups. Straight leg raise was negative bilaterally. Utilization review determination dated 07/01/13 non-certified requests for Hydrocodone/APAP 10/325mg #60, Fentanyl disc 50mcg/hour #10 day supply, Carisoprodol tablets 350mg #20 day supply, Methocarbamol tablets 500mg #40 day supply, and Oxycodone tablet 30mg #90 day supply.

IMR ISSUES, DECISIONS AND RATIONALES

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

HYDROCODONE/APAP TAB 10/325MG #60: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78-79,29.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opiates
Page(s): 74-80.

Decision rationale: The request is recommended as medically necessary. The submitted clinical records indicate that the injured worker is status post lumbar fusion in 08/11. The injured worker has a failed back surgery syndrome and underwent revision surgery for pseudoarthrosis which was performed on 10/10/13. Between 01/07/13 through 10/10/13 the injured worker was suffering from failed back surgery syndrome and hydrocodone APAP 10/325 mg would be supported as medically necessary for pain control based on Chronic Pain Medical Treatment Guidelines.

FENTANYL DISC 50MCG/HR QUANTITY 10 DAY SUPPLY 30: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
Page(s): 78-79,29.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opiates
Page(s): 74-80.

Decision rationale: The request is recommended as medically necessary. The submitted clinical records indicate that the injured worker was suffering from a failed back surgery syndrome. The use of fentanyl to as a long acting opiate for steady control of pain would be supported as medically necessary based on Chronic Pain Medical Treatment Guidelines.

CARISOPRODOL TAB 350MG QUANTITY 20 DAY SUPPLY 20: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
Page(s): 78-79,29.

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

Decision rationale: The request is not medically necessary. The submitted clinical records indicate that the injured worker suffers from failed back surgery syndrome and is pending surgery. Medical records do not document severe myospasm for which this medication would be indicated. Additionally, it would be noted that Chronic Pain Medical Treatment Guidelines does not support the use of Soma due to its side effects and addictive properties. As such the request would not be supported as medically necessary based on Chronic Pain Medical Treatment Guidelines.

METHOCARBAMOL TAB 500MG QUANTITY 40 DAY SUPPLY 10: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
Page(s): 78-79,29.

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

Decision rationale: The request is not supported as medically necessary based on Chronic Pain Medical Treatment Guidelines. The submitted clinical records indicate that the injured worker suffers from failed back surgery syndrome. The records do not report myospasm for which this medication would be clinically indicated. As such medical necessity would not be established given the lack of objective findings on examination.

OXYCODONE TAB 30MG QUANTITY 90 DAY SUPPLY 30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78-79, 29.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opiates Page(s): 74-80.

Decision rationale: The request is not medically necessary. Records indicate that the injured worker is receiving Hydrocodone/APAP 10/325mg and Fentanyl disc 50mcg/hour. The use of oxycodone would be considered redundant medication and therefore not medically necessary based on Chronic Pain Medical Treatment Guidelines.