MAXIMUS Federal Services

Case Number:	CM13-0047887		
Date Assigned:	12/27/2013	Date of Injury:	09/19/1994
Decision Date:	04/25/2014	UR Denial Date:	10/04/2013
Priority:	Standard	Application Received:	11/04/2013

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 Physical Medicine and Rehabilitation, has a subspecialty in Neuromuscular Medicine and is licensed to practice in Maryland. 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 patient is a 63 year old female. She has a date of injury 9/19/94.Her diagnoses include low back pain, post lumbar laminectomy syndrome, neuralgia/neuritis, lumbar sprain/ DDD, spasm of muscle . There are requests for the medical necessity of Soma, Senna, OxyContin and Percocet. Per a 12/19/13 PR-2 visit the patient complains that her pain level has increased since last visit. She denies new problems 01' side-effects. Her quality of sleep is poor. Her level has remained the same. Her 6/6/13 CURES is appropriate. On physical examination the patient has an antalgic slow gait. She is assisted with a cane. Her lumbar spine has a surgical scar. Her lumbar range of motion is limited. A straight leg raise test is negative. There is tenderness to palpation on paravertebral muscles. A Fabere and Babinski test are negative. All reflexes are equal and symmetric. There is tenderness over the sacroiliac joint. There is a trigger point with radiating twitch response on palpation of the lumbar paraspinal muscles on left and right. Motor strength is 5/5 in the bilateral extremities on both legs in ankle dorsiflexion, plantar flexion, knee extension. There is normal muscle tone. Light touch sensation is intact all over body. Per this documentation patient is permanent and stationary working full time as an educator. Per documentation she has been stable and compliant on her current pain regimen for over 6 months.

IMR ISSUES, DECISIONS AND RATIONALES

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

PHARMACY PURCHASE OF SENNA 8.6MG #180 WITH 2 REFILLS: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation NON-MTUS

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines INITIATING THERAPY Page(s): 77.

Decision rationale: Pharmacy purchase of Senna 8.6mg #180 with 2 refills is not medically necessary per the MTUS guidelines. The guidelines do recommend prophylactic treatment of constipation should be initiated with opioid use, it is determined elsewhere in this review that opioids are not medically necessary. Additionally, the request does not specific the frequency of use. Therefore, the request for pharmacy purchase of Senna 8.5 mg #180 with 2 refills is not medically necessary.

SOMA 350MG #120 WITH 2 REFILLS: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation NON-MTUS

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CARISOPRODOL Page(s): 65.

Decision rationale: Soma 350mg #120 with 2 refills is not necessary per MTUS guidelines. The MTUS does not recommend this medication for more than a 2-3 weeks period and this is second line for acute exacerbations of chronic low back pain. Documentation does not indicate an acute exacerbation of low back pain. The quantity requested is for greater than a 2-3 week period. Patient has been on this medication since at least Sept. 2012 if not longer. There is no specific quantity requested of this medication. The request for Soma 350mg #120 with 2 refills is not medically necessary.

OXYCONTIN 40MG #270 WITH 2 REFILLS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS FOR CHRONIC PAIN..

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ON GOING MANAGEMENT Page(s): 78-79.

Decision rationale: OxyContin 40mg #270 with 2 refills is not medically necessary per the MTUS guidelines. The guidelines states that opioids should be discontinued if there is no significant improvement in pain levels. The patient has had both Percocet and OxyContin prescribed since at least 1997. The documentation submitted reveals patient continues to have significant pain. Per the 12/19/13 office visit the documentation states that the, "Pain level has increased since last visit .No new problems or side-effects. Quality of sleep is poor. Activity level has remained the same." Furthermore, the MTUS states that the documentation of pain assessment should include current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain

relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Per documentation patient's pain level has not improved significantly on pain meds. Furthermore, the request does not indicate how often patient is to take her OxyContin. The request for OxyContin 40mg #270 with 2 refills is not medically necessary.

PERCOCET 10/325MG #270 WITH 2 REFILLS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS FOR CHRONIC PAIN,.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ON GOING MANAGEMENT Page(s): 78-79.

Decision rationale: Percocet 10/325mg #270 with 2 refills is not medically necessary per the MTUS guidelines. The guidelines states that opioids should be discontinued if there is no significant improvement in pain levels. The patient has had both Percocet and OxyContin prescribed since at least 1997. The documentation submitted reveals patient continues to have significant pain. Per the 12/19/13 office visit the documentation states that the, "Pain level has increased since last visit .No new problems or side-effects. Quality of sleep is poor. Activity level has remained the same." Furthermore, the MTUS states that the documentation of pain assessment should include current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Per documentation patient's pain level has not improved significantly on pain meds. Furthermore, the request does not indicate how often patient is to take her Percocet. The request for Percocet 10/325mg #270 with 2 refills is not medically necessary.