

Case Number:	CM13-0068995		
Date Assigned:	01/03/2014	Date of Injury:	12/05/2008
Decision Date:	04/21/2014	UR Denial Date:	12/02/2013
Priority:	Standard	Application Received:	12/20/2013

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 Pain Medicine 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 patient is a 47-year-old male who was injured on 12/05/2008 while he was injured when he fell off ladder. Prior treatment history has included lumbar spine surgery, microdiscectomy 07/27/2009, post-op physical therapy and lumbar epidural steroid injection. Diagnostic studies reviewed include lumbar MRI dated 11/2009 which revealed L5-S1 broad-based disc protrusion with associated annular fissure resulting in mild narrowing of the canal. L4-5 broad-based disc protrusion was mildly narrowing the canal. Per AME Supplemental report dated 05/29/2013 the lumbar scan performed 03/13/2013 did reveal some residual pathology on the left at the L4-5 level, however, this was described as persistent minimal left subarticular and proximal foraminal stenosis with a 2 mm left lateral bulging annulus and annular fissure or tear persisting. An EMG dated 04/02/2013 revealed no evidence of entrapment neuropathy in lower extremities. PR-2 dated 07/09/2013 documented the patient to have complaints of the pain not subsiding with OxyContin 20 mg. Treatment plan: OxyContin was increased back to 30 mg per day. PR-2 dated 08/06/2013 documented the patient had a discogram done since his last visit. He states the discogram caused a lot of pain during the procedure, however, it felt like an epidural and he had minimal tolerable pain for two to three days. After those three days, the pain came back significantly. Still takes medication for pain depending on the pain level. Treatment Plan: Given a refill of his medications today. PR-2 dated 09/10/2013 documented the patient with complaints that his low back pain is still excruciating. He rates his back pain as 8 out of 10. He is complaining of much decreased quality of life due to the pain and the inability to do anything without his back pain being exacerbated. The patient continues to take medications for his pain. Objective findings on exam included examination of the cervical spine showing paravertebral muscles are tender to palpation. Spasm is present. Range of motion is restricted. Positive Spurling's test on the left. Examination of the lumbar spine reveals paravertebral muscles tender.

Spasm is present. Range of motion is restricted. Sensation is reduced in bilateral L5 dermatomal distribution. Straight leg raising test is positive bilaterally. Achilles tendon reflex is absent bilaterally. Treatment Plan: Continue taking medications as before and a refill was provided: hydrocodone (Norco) two tablets po bid prn #120, ketoprofen 75 mg po once daily #30, omeprazole DR 20 mg once daily #30, oxycodone HCLR IR 10 mg one tablet po bid prn #60, Amrix ER 15 mg one tablet po #30, OxyContin ER 30 mg one tablet po bid #60 and Lidoderm patch 5% (700 mg patch) 1-2 patches to be applied on for 12 hours and off for 12 hours #60. PR-2 dated 11/05/2013 documented the patient with complaints that his symptoms have worsened. His back pain is persistently worsened. He has been anxious to go to surgery but surgery has not been authorized at this point. Objective findings on exam include cervical spine paravertebral muscles are tender to palpation. Spasm is present. Range of motion is restricted. Paravertebral muscles in the lumbar spine are tender. Spasm is present. Range of motion is restricted. Sensation is reduced in bilateral L5 dermatomal distribution. Straight leg raising test is positive bilaterally. Achilles tendon reflex is absent bilaterally. Impression: 1. cervical radiculopathy 2. lumbar radiculopathy 3. anxiety reaction. Treatment Plan: Oxycodone increased to one tablet three times a day and occasionally the patient will take the oxycodone instead of OxyContin.

IMR ISSUES, DECISIONS AND RATIONALES

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

PRESCRIPTION OF 60 OXYCODONE 10MG: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 76.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 88-92.

Decision rationale: er the CA MTUS chronic pain guidelines, long-term users of opioids should have documented pain and functional improvement, satisfactory response to treatment or improved quality of life. The records indicate the patient has been prescribed OxyContin and Oxycodone and has increased pain and complaints of "much decreased quality of life due to the pain". Based on the absence of documented pain and functional improvements, the request is not medically necessary. The guides' further state, "Gradual weaning is recommended for long-term opioid users because opioids cannot be abruptly discontinued without probable risk of withdrawal symptoms."