

Case Number:	CM14-0009585		
Date Assigned:	02/14/2014	Date of Injury:	08/13/2008
Decision Date:	08/07/2014	UR Denial Date:	12/24/2013
Priority:	Standard	Application Received:	01/24/2014

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 Occupational 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 56-year-old male who has submitted a claim for lumbar radiculopathy, lumbar failed surgery syndrome, status post lumbar fusion, iatrogenic opioid dependency, chronic pain, and insomnia associated with an industrial injury date of 08/13/2008. The medical records from 2013 were reviewed. The patient complained of low back pain radiating to bilateral lower extremities, graded 6/10 in severity. Intake of medications did not decrease the pain severity scale. This resulted to difficulties in self-care / hygiene, ambulation, and sleep. The physical examination of the lumbar spine showed tenderness, muscle spasm, and restricted range of motion. Gait was antalgic and slow. Motor and sensory exam were both normal. The treatment to date has included medications such as Fioricet, tramadol, suboxone, and amitriptyline.

IMR ISSUES, DECISIONS AND RATIONALES

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

SUBOXONE 8 MG - 2 MG #45 WITH ONE REFILL: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Buprenorphine Page(s): 26-27.

Decision rationale: According to pages 26-27 of CA MTUS Chronic Pain Medical Treatment Guidelines, buprenorphine is recommended for treatment of opiate addiction. It is also an option for chronic pain, especially after detoxification in patients with a history of opiate addiction. The patient has been on this medication since at least January 2013. The patient has a known case of opioid dependency; hence, the medical necessity for Suboxone is established. Therefore, the request for Suboxone 8 mg - 2 mg #45 with one refill is medically necessary.

AMITRIPTYLINE HCL 50 MG #30 WITH ONE REFILL: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for Chronic Pain Page(s): 14.

Decision rationale: As stated on page 14 of the CA MTUS Chronic Pain Medical Treatment Guidelines, tricyclic antidepressants, such as amitriptyline and nortriptyline, are recommended as a first-line option for neuropathic pain, especially if pain is accompanied by insomnia, anxiety, or depression. In this case, patient has been on amitriptyline since April 2013 for insomnia. However, there was no documentation concerning functional improvement derived from its use. Moreover, there was no discussion of patient's sleep hygiene. The medical necessity cannot be established due to insufficient information. Therefore, the request for Amitriptyline HCL 50 mg #30 with one refill is not medically necessary.

ONE URINE DRUG SCREEN: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-going Management Page(s): 78.

Decision rationale: Page 78 of the CA MTUS Chronic Pain Medical Treatment Guidelines state that urine drug screens are recommended as an option to assess order use or presence of illegal drugs and as ongoing management for continued opioid use. Screening is recommended randomly at least twice and up to 4 times a year. In this case, patient has a known chronic opioid dependency; hence, frequent drug screen was implemented. Urine drug screens were performed on 8/19/13, 6/24/2013, and 10/14/13; results were inconsistent with prescribed medications. However, there was no management response concerning this. The medical necessity for another urine drug screen cannot be established due to insufficient information. Therefore, the request for urine drug screen is not medically necessary.

SOMA 350 MG #60: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines SOMA (CARISOPRODOL).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol (Soma) Page(s): 29.

Decision rationale: As stated on page 29 of the CA MTUS Chronic Pain Medical Treatment Guidelines, carisoprodol (Soma) is a centrally acting skeletal muscle relaxant that is not indicated for long-term use. Carisoprodol abuse has been noted in order to augment or alter effects of other drugs such as hydrocodone, tramadol, benzodiazepine and codeine. In this case, there was no previous use of Soma based on the records submitted. The most recent progress report cited presence of muscle spasm at the paralumbar area. Prescribing Soma is a reasonable option at this time. Therefore, the request for soma 350 mg #60 is medically necessary.