

<b>Case Number:</b>	CM14-0117555		
<b>Date Assigned:</b>	08/06/2014	<b>Date of Injury:</b>	09/30/1997
<b>Decision Date:</b>	09/10/2014	<b>UR Denial Date:</b>	07/21/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/25/2014

### 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:

This case involves a male injured worker who was injury on 9/30/1997. Per pain specialist progress report dated 6/16/2014, the injured worker complains of back pain with a severity level of moderate to severe. The pain is located in his middle back, lower back, gluteal area and legs. It radiates to his left ankle, right ankle, left calf, right calf, left foot, right foot, left thigh and right thigh. He describes the pain as an ache, deep, discomforting, dull, localized, numbness and piercing. Symptoms are aggravated by ascending and descending stairs, bending, daily activities, extension and flexion, jumping, lifting, lying or rest, pushing, sitting, standing and twisting. Symptoms are relieved by exercise, ice massage, movement, over the counter medication, pain medications, stretching and rest. The pain is rated at 8/10 without medications and 6/10 with medications. Lumbar extension is 25 degrees and flexion is 25 degrees. He displays anhedonia and hopelessness with depressed mood and affect. The injured worker is status post four lumbar surgeries and continues to struggle with pain and depression secondary to his loss of function and pain over time.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Kardian 20mg #90:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids section, page(s) 74-95 Page(s): 74-95.

**Decision rationale:** The injured worker has been treated with Kadian, and per the requesting physician, it allows him to maintain his function. With the use of chronic opioids the injured worker is able to get out of bed and get out of the house regularly. The MTUS Guidelines do not recommend the use of opioid pain medications, in general, for the management of chronic pain. There is guidance for the rare instance where opioids are needed in maintenance therapy, but the emphasis should remain on non-opioid pain medications and active therapy. Long-term use may be appropriate if the patient is showing measurable functional improvement and reduction in pain in the absence of non-compliance. Functional improvement is defined by either significant improvement in activities of daily living or a reduction in work restriction as measured during the history and physical exam. The medical documentation reports that the injured worker is on chronic pain medications and he needs these medications to remain functional. The requesting physician is also taking measures to assess for adherent behavior that may necessitate immediate discontinuation of the medications. The injured worker's opioid medication dosing has remained stable and he appears to be in a maintenance stage of his pain management. As such, the request for Kadian 20 mg #90 is determined to be medically necessary.

**Ditropan XL 15mg #30:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Ditropan XL accessed via world wide web at <http://www.drugs.com/ditropan.html>.

**Decision rationale:** The injured worker has been taking Ditropan XL every morning since 2012 at the recommendation of an urologist for excessive post void dribbling. Although the UR decision is provided for review, the report was partially missing and no UR decision rationale was provided. If this is an AOE/COE issue, that determination is beyond the scope of this review. The use of Ditropan XL for urinary incontinence as recommended by the specialist in urology is consistent with the primary uses of this medication. The request for Ditropan XL 15 mg #30 is determined to be medically necessary.