

Case Number:	CM14-0120145		
Date Assigned:	08/06/2014	Date of Injury:	02/22/2010
Decision Date:	09/12/2014	UR Denial Date:	07/10/2014
Priority:	Standard	Application Received:	07/29/2014

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 Neurology, has a subspecialty in Pain Medicine and is licensed to practice in Florida. 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:

5/16/14 clinical questionnaire notes complaints of stomach pain, low back pain and spasms, pain down the left leg and knee and not sleeping. Medications are listed as "oxy, voltaren gel, tamezepam, and Xanax." 4/16/14 note indicates report of continued pain since 2/22/10. The treating physician notes the insured was recommended to have spinal fusion and has an abdominal hernia. There is pain in the stomach, low back, and also pain radiating down the left leg and knee. Examination notes mentation was normal with tenderness over the left shoulder and lumbar paraspinals. There was some abdominal tenderness with normal strength, sensation, and reflexes in the upper and lower extremities. The diagnosis was reported as cervical disc disease with h/o lumbar spinal surgery with fusion and continued pain in need of removal of hardware. The treating physician recommended the continued use of oxycodone, soma and the trial use of fentanyl patches.

IMR ISSUES, DECISIONS AND RATIONALES

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

Oxycodone 10/325mg #120: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) low back, opioids.

Decision rationale: The medical records provided for review do not indicate or document the degree of pain relief or effect of the opioid medication in support of continued utilization. There is no documentation opioid risk mitigation monitoring such as UDS or documentation of monitoring for aberrant behavior. There is no documentation of functional assessment in support of continued opioid prescription. ODG supports for continued opioid use, that ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. 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. The request is not medically necessary.

Fentanyl Patches 50mg #10: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Duragesic. Decision based on Non-MTUS Citation Official Disability Guidelines/Pain Chapter on Fentanyl (FDA, 2011)ODG/Pain chapter on Duragesic (Coventry, 2012).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) low back, opioids.

Decision rationale: The medical records provided for review do not indicate or document the degree of pain relief or effect of the opioid medication in support of continued utilization. There is no documentation opioid risk mitigation monitoring such as UDS or documentation of monitoring for aberrant behavior. There is no documentation of functional assessment in support of continued opioid prescription. ODG supports for continued opioid use, that ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. 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. The request is not medically necessary.

Soma 350mg #90 with 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol (Soma)- Muscle relaxant. Decision based on Non-MTUS Citation Official Disability Guidelines 2013 (DEA, 2012) Beers Criteria: The AGS updated Beers criteria for inappropriate medication use includes carisoprodol. This is a list of potentially inappropriate medications for older adults. (AGS, 2012).

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

Decision rationale: MTUS guidelines do not support long term use of Soma. The medical records provided for review do not indicate or document the degree of functional benefit in support of continued utilization. There is no indication of treatment failure with other standard therapy muscle relaxants or indication in regard to the insured to support mitigating reason soma should be used in the insured. This request is not medically necessary.