

Case Number:	CM14-0153795		
Date Assigned:	09/23/2014	Date of Injury:	12/07/2005
Decision Date:	11/25/2014	UR Denial Date:	09/02/2014
Priority:	Standard	Application Received:	09/19/2014

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 Physical Medicine and Rehabilitation 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 claimant is status post work-related injury occurring on 12/07/05. She underwent a lumbar spine decompression and fusion in September 2006. She continues to be treated for chronic back, bilateral thigh, and right forearm pain. She was seen by the requesting provider on 08/14/14. She was having constant low back pain radiating into the left lower extremity and progressive right lower extremity weakness. Prior treatments had included a Toradol injection with decreased pain. Medications included Oxycodone reported to allow household activities and decreasing pain, Neurontin with decreased right upper extremity burning symptoms, Elavil with improved sleep, and Zanaflex referenced as working well in the past with decreased spasms. There had been no benefit with Flexeril. Physical examination findings included appearing in slight to moderate discomfort. She had a stiff gait. Cervical spine range of motion was guarded. She had decreased right upper extremity sensation. There was diffuse lumbosacral, upper buttock, and bilateral sacroiliac joint tenderness with decreased lumbar spine range of motion. Patrick testing was positive. There is reference to a mildly positive left straight leg raise. Authorization for a left lumbar facet injection was requested. Oxycodone 15 mg #150, Flexeril 10 mg #90, Lorazepam 1 mg #30, and Neurontin 300 mg #360 were refilled.

IMR ISSUES, DECISIONS AND RATIONALES

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

Oxycodone 20mg 3 - 4 day #120: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OxyContin; Long-acting opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use, Opioids, dosing Page(s): 76-80, 86.

Decision rationale: The claimant is nearly 9 years status post work-related injury and continues to be treated for chronic back, bilateral thigh, and right forearm pain. Medications include Oxycodone being prescribed at a total MED (Morphine Equivalent Dose) of 120 mg/day and reported as decreasing pain and allowing household activities. Guidelines indicate that when an injured worker has reached a permanent and stationary status or maximal medical improvement that does not mean that they are no longer entitled to future medical care. When prescribing controlled substances for pain, satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Oxycodone is a short acting Opioid often used for intermittent or breakthrough pain. In this case, it is being prescribed as part of the claimant's ongoing management. There are no identified issues of abuse, addiction, or poor pain control. There are no inconsistencies in the history, presentation, the claimant's behaviors, or by physical examination. Her total MED is 120 mg per day consistent with guideline recommendations. Therefore, the continued prescribing of Oxycodone was medically necessary.

Lorazepam 1 mg 1 / day #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

Decision rationale: The claimant is nearly 9 years status post work-related injury and continues to be treated for chronic back, bilateral thigh, and right forearm pain. Benzodiazepine medications are not recommended for long-term use. Long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. Gradual weaning is recommended for long-term users. Therefore the ongoing prescribing of Lorazepam is not medically necessary.

Soma 350mg 3/day #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol Page(s): 29. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Carisoprodol/Soma

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

Decision rationale: The claimant is nearly 9 years status post work-related injury and continues to be treated for chronic back, bilateral thigh, and right forearm pain. Soma (carisoprodol) is a

muscle relaxant which is not recommended and not indicated for long-term use. Meprobamate is its primary active metabolite and the Drug Enforcement Administration placed carisoprodol into Schedule IV in January 2012. It has been suggested that the main effect is due to generalized sedation and treatment of anxiety, and abuse has been noted for its sedative and relaxant effects. Continued prescribing is not medically necessary.