MAXIMUS Federal Services

Case Number:	CM14-0154317		
Date Assigned:	09/23/2014	Date of Injury:	11/08/1985
Decision Date:	10/24/2014	UR Denial Date:	09/15/2014
Priority:	Standard	Application Received:	09/22/2014

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 & Rehabilitation , has a subspecialty in Pain Medicine and is licensed to practice in Texas and Oklahoma 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 injured worker is a 58-year-old female who reported an injury on 11/08/1995. The mechanism of injury was not submitted for clinical review. The diagnoses included lumbar laminectomy syndrome, spinal lumbar degenerative disc disease, lumbar radiculopathy, chronic back pain, and hip bursitis. The previous treatments included medication and surgery. Diagnostic testing included an MRI. Within the clinical note dated 08/22/2014 it was reported the injured worker complained of low back pain. She rated her pain 6/10 in severity with medication and 10/10 in severity without medication. Upon the physical examination, the provider noted the lumbar spine revealed asymmetry and increased kyphosis. The range of motion was restricted with flexion limited to 80 degrees and limited by pain, and extension at 10 degrees. The paravertebral muscles had tenderness and spasms, left greater than right. The injured worker had positive lumbar facet loading on the left side. The provider requested carisoprodol, Norco, OxyContin, and Lunesta. However, the rationale was not submitted for clinical review. The Request for Authorization was not submitted for clinical review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Carisoprodol 350mg #56: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MUSCLE RELAXANTS Page(s): 63, 64.

Decision rationale: The request for Carisoprodol 350mg #56 is not medically necessary. The California MTUS Guidelines recommend non-sedating muscle relaxants with caution as a second line option for short term treatment of acute exacerbations in patients with chronic low back pain. The guidelines recommend the medication is not to be used for longer than 2 to 3 weeks. There is a lack of documentation indicating the efficacy of the medication as evidence by significant functional improvement. The request submitted failed to provide the frequency of the medication.

Norco 10/325mg #84: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS, CRITERIA FOR USE, ON-GOING MANAGEMENT Page(s): 78.

Decision rationale: The request for Norco 10/325mg #84 is not medically necessary. The California MTUS Guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The guidelines recommend the use of a urine drug screen or inpatient treatment with issues of abuse, addiction, or poor pain control. There is a lack of documentation indicating the medication had been providing objective functional benefit and improvement. The request submitted failed to provide the frequency of the medication. Additionally, the provider failed to document an adequate and complete pain assessment within the documentation. The use of a urine drug screen was not submitted for clinical review.

Oxycontin 80mg #252: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS, CRITERIA FOR USE, ON-GOING MANAGEMENT Page(s): 78.

Decision rationale: The request for Oxycontin 80mg #252 is not medically necessary. The California MTUS Guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The guidelines recommend the use of a urine drug screen or inpatient treatment with issues of abuse, addiction, or poor pain control. There is a lack of documentation indicating the medication had been providing objective functional benefit and improvement. The request submitted failed to provide the frequency of the medication. Additionally, the provider failed to document an adequate and

complete pain assessment within the documentation. The use of a urine drug screen was not submitted for clinical review.

Lunesta 3mg #25: Upheld

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

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

Decision rationale: The request for Lunesta 3mg #25 is not medically necessary. The Official Disability Guidelines do not recommend Lunesta for long term use, but recommend it for short term use. The guidelines recommend that insomnia treatment be based on the etiology. Pharmacological agents should only be used after careful evaluation of potential cases of sleep disturbances. There is a lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. Additionally, there is a lack of clinical documentation indicating the injured worker was treated for insomnia.