

<b>Case Number:</b>	CM14-0061653		
<b>Date Assigned:</b>	08/06/2014	<b>Date of Injury:</b>	07/06/2004
<b>Decision Date:</b>	09/10/2014	<b>UR Denial Date:</b>	04/07/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/02/2014

### 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 Anesthesiology, has a subspecialty in Pain 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 injured worker is a 55 year old male who is reported to have sustained work related injuries on 07/06/04. No mechanism of injury is described. Records indicate that the injured worker has chronic low back pain with radiation into the left lower extremity. Per the historical records, the patient is status post an L4-5 disc replacement in 2006 and an L5-S1 fusion in 2008. The records indicate that the injured worker has depression secondary to chronic pain. The psychiatric notes indicate that the injured worker is prescribed Seroquel for this condition and he is noted to be stable. The submitted clinical records do not provide any detailed physical examinations. He is noted to be well-developed and well-nourished and in no apparent distress. Affect is appropriate. There is no evidence of neurologic deficits. He is reported to have benefit from oral medications; however, this is not quantified. The records do not contain any urine drug screens; however, a clinical note reports that a urine drug screen was performed and noted to be consistent. His pain is reported to be 6/10 while on medications. The record contains a utilization review determination dated 04/07/14 in which requests for Seroquel XR 200mg #30, Celebrex 200mg #30, Lunesta 30mg #30, Carisoprodol 350mg #30, Morphine Sulfate 80mg #30 and Oxycodone HCL 30mg #30 were non-certified.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Seroquel XR 200 mg # 30:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): PTSD pharmacology.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness and Stress, Atypical Anti-psychotics.

**Decision rationale:** The request for Seroquel XR 200mg #30 is medically necessary. The serial records indicate that the injured worker has chronic pain syndrome which has resulted in major depression. His psychiatric records indicate that the injured worker benefits from Seroquel XR 200mg and that his condition is stable as a result. Given this information, there is sufficient data to continue to support the use of this medication.

**Celebrex 200 mg #30:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti--Inflammatories. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Anti--Inflammatories Physician Desk Reference <http://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0009526/>.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Celebrex Page(s): 30.

**Decision rationale:** The request for Celebrex 200mg #30 is not medically necessary. The submitted clinical records indicate that the injured worker is status post an apparent disc replacement and L5-S1 fusion. Per Official Disability Guidelines, Celebrex is clinically indicated in the presence of osteoarthritis in injured workers who cannot tolerate non-steroidal anti-inflammatory drugs. As there is no data provided to suggest that the injured worker has osteoarthritis for which this medication would be indicate, is not medically necessary.

**Lunesta 3 mg #30:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Evidence Based 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 Chapter, Sleep Aids.

**Decision rationale:** The request for Lunesta 3mg #30 is not medically necessary. Both California Medical Treatment Utilization Schedule and Official Disability Guidelines support the short term use of sleep aides for the normalization of sleep. The record does not provide any data to suggest that the injured worker has sleep disturbance. Further, this is a chronic injury and therefore, long term use is not supported under the guidelines.

**Carisoprodol 350 mg #30: Upheld**

**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 Carisoprodol (Soma) Page(s): 29.

**Decision rationale:** The request for Carisoprodol 350mg #30 is not medically necessary. The submitted clinical records do not indicate the presence of active myospasms. The physical examinations provided are brief and do not provide specific data. As such, the continued use of Carisoprodol 350mg would not be supported as medically necessary.

**Morphine Sulfate 80 mg #30: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Mixed Pharmacology Page(s): 79-81. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Mixed Pharmacology Evidence Based Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opiates Page(s): 74-80.

**Decision rationale:** The request for Morphine Sulfate 80mg #30 is not supported as medically necessary. The records reflect that the injured worker most likely has failed back surgery syndrome and chronic pain syndrome. He is noted to have 6/10 pain with medications. The injured worker has chronically been maintained on opiate medications without evidence of substantive benefit. It is reported that the injured worker has functional improvements but these are generalized statements and do not quantify the nature and degree of functional improvements as a result of this medication. In addition to this, there is no documentation establishing that the injured worker has a signed pain management contract or undergoes routine or random urine drug screens to assess compliance. As there is no substantive data establishing functional improvements, continuation of this medication is not supported as medically necessary.

**Oxycodone HCL 30 mg #30: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Mixed Pharmacology Page(s): 79-81. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Mixed Pharmacology Evidence Based Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opiates Page(s): 74-80.

**Decision rationale:** The request for Oxycodone HCL 30mg #30 is not supported as medically necessary. The submitted clinical records do not indicate the presence of active myospasms. The physical examinations provided are brief and do not provide specific data. As such, the continued use of Oxycodone HCL 30mg #30 would not be supported as medically necessary.

