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| Case Number: | CM14-0076921 | | |
| Date Assigned: | 07/18/2014 | Date of Injury: | 08/15/2008 |
| Decision Date: | 09/18/2014 | UR Denial Date: | 05/12/2014 |
| Priority: | Standard | Application Received: | 05/27/2014 |

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 Nevada. 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 64-year-old female was reportedly injured on August 15, 2008. The mechanism of injury is not listed in these records reviewed. The most recent progress note dated April 25, 2014, indicates that there are ongoing complaints of low back pain and neck pain. The back pain was stated to radiate to both lower extremities. There were also complaints of depression and anxiety. The physical examination demonstrated ambulation with an antalgic gait favoring the right lower extremity. There was a 1+ bicep reflects on the right and absent triceps reflex. There was also decreased sensation at the C6 and C8 dermatomes bilaterally. Diagnostic imaging studies were not reviewed during this visit. Previous treatment includes epidural steroid injection. A request was made for oxycodone, Buspirone and a lumbar orthosis and was not approved in the pre-authorization process on May 12, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Oxycodone 10mg #150: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use; Weaning of Medications; Opioids, dosing.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-78, 88, 91 OF 127.

Decision rationale: Oxycodone is a short acting opiate indicated for the management of moderate to severe breakthrough pain. The California Medical Treatment Utilization Schedule guidelines support short-acting opiates at the lowest possible dose to improve pain and function, as well as the ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The injured employee has chronic pain; however, there is no objective clinical documentation of improvement in their pain or function with the current regimen. As such, this request for oxycodone is not medically necessary.

Buspirone 10mg #60 with 1 refill: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain (Chronic): Anxiety medications in chronic pain.

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: <http://www.nlm.nih.gov/medlineplus/druginfo/meds/a688005.html>.

Decision rationale: Buspirone is a medication used to treat anxiety disorders or the short-term treatment of the symptoms of anxiety. The most recent progress note dated April 25, 2014, does state that the injured employee has symptoms of anxiety. A review of the medical record also indicates previous treatment of anxiety with Benzodiazepines, which have been discontinued. Considering this, this request for Buspirone is medically necessary.

Lumbo-Sacral Orthosis: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298, 301.

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 - Lumbar and Thoracic, Lumbar Supports, Updated August 22, 2014.

Decision rationale: According to the Official Disability Guidelines, lumbar supports are not recommended for prevention of low back pain. There is evidence that they may be effective as a treatment option for compression fractures or the treatment of spondylolisthesis and documented instability. As the injured employee has not been diagnosed with these conditions, this request for a lumbosacral orthosis is not medically necessary.