

Case Number:	CM14-0082100		
Date Assigned:	07/21/2014	Date of Injury:	11/08/1985
Decision Date:	09/24/2014	UR Denial Date:	05/30/2014
Priority:	Standard	Application Received:	06/04/2014

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 Family 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 58 year old female who sustained injuries to her low back on 11/08/85. Mechanism of injury was not described. The injured worker was noted to have a failed back surgery syndrome. Her pain levels were reported to be 10/10 without medications and 5/10 with. Her quality of sleep was poor and her activity level remained the same. The injured worker underwent multiple interventional procedures including a left S1 transforaminal epidural steroid injection. On 08/18/03, the injured worker underwent administration of botulinum toxin type A. On 12/02/04 the injured worker underwent bilateral rhomboid trigger point injections. Bilateral sacroiliac joint injections and caudal epidural steroid injections on 06/25/08 and more recently on 01/05/11. Most recent physical examination dated 06/19/14 indicated that The injured worker was well groomed well-nourished and well developed. The injured worker appeared anxious and fatigued and in mild pain and showed no evidence of intoxication or withdrawal. The injured worker had a slow stooped gait and was assisted by a cane. The injured worker had increased lumbar kyphosis (hump back). Lumbar range of motion was reduced. The injured worker had tenderness to palpation of paravertebral muscles left greater than right. Facet loading was positive on the left. Straight leg raise was negative. Patellar and ankle jerks were absent bilaterally. Motor strength was 4/5 on the right EHL and 3/5 on the left. Ankle dorsiflexions were graded 4/5 on the left the remainder was 5/5. Straight leg raise was positive on the left. CURES was appropriate. The initial request for Oxycontin 80 MG # 49, Carisoprodol 350 MG # 14, and Norco 10/325 MG # 21 was non-certified on 05/30/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Oxycontin 80 MG # 49: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Oxycontin Page(s): 80-81.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 77.

Decision rationale: The Chronic Pain Medical Treatment Guidelines, patients must demonstrate functional improvement in addition to appropriate documentation of ongoing pain relief to warrant the continued use of narcotic medications. There is no clear documentation regarding the functional benefits or any substantial functional improvement obtained with the continued use of narcotic medications. Specific examples of improved functionality should be provided to include individual activities of daily living, community activities, and exercise as a result of medication use. As such, Oxycontin 80 MG # 49 is not medically necessary and appropriate.

Carisoprodol 350 MG # 14: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, muscle relaxant.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol Page(s): 65.

Decision rationale: As noted on page 65 of the Chronic Pain Medical Treatment Guidelines, Soma is not recommended for long-term use. This medication is FDA-approved for symptomatic relief of discomfort associated with acute pain in musculoskeletal conditions as an adjunct to rest and physical therapy. The documentation indicates that the patient is being prescribed the medication for chronic pain and long-term care exceeding the recommended treatment window. As such, the request for Carisoprodol 350 MG # 14 cannot be recommended as medically necessary.

Norco 10/325 MG # 21: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 77.

Decision rationale: The Chronic Pain Medical Treatment Guidelines, patients must demonstrate functional improvement in addition to appropriate documentation of ongoing pain relief to warrant the continued use of narcotic medications. There is no clear documentation regarding the functional benefits or any substantial functional improvement obtained with the continued use of narcotic medications. Specific examples of improved functionality should be provided to

include individual activities of daily living, community activities, and exercise as a result of medication use. As such, Norco 10/325 mg # 21 is not medically necessary and appropriate.