

<b>Case Number:</b>	CM14-0088168		
<b>Date Assigned:</b>	07/23/2014	<b>Date of Injury:</b>	08/21/2001
<b>Decision Date:</b>	09/24/2014	<b>UR Denial Date:</b>	05/19/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/12/2014

### 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 Louisiana. 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 patient is a 41-year-old male who was injured on 08/21/2001. The mechanism of injury is unknown. The patient's medications as of 02/19/2014 included oxycodone 80 mg Soma (Carisoprodol) 350 mg, Subsys 800 mcg, and Zanaflex 60. Her medications as of 11/07/2013 included Oxycontin 80 mg, Percocet, Soma, Subsys, and Zanaflex (VAS 7/10). The patient underwent placement of prodisc artificial prosthesis on 03/04/2003. Progress report dated 02/19/2014 indicates the patient presented with complaints of chronic lumbar pain and leg pain. He reported the trial of Norco did not work as well and his quality of sleep is poor and averages 4-5 hours of interrupted sleep per night. He rated his pain as 8/10. On exam, he continued to have pain radiating to his legs. He has increased pain with sitting and standing. He is diagnosed with chronic severe low back pain, falling/moving artificial disc at L5/S1; myofascial pain/spasm; unspecified myositis and myalgia. The patient was instructed to continue with medications including Zanaflex, Subsys, methadone, Cymbalta, Oxycontin 80 mg, Soma 350 mg, Norco 10/325 mg, Oxycodone 20 mg; and Lazanda 400 ugm. Prior utilization review dated 05/19/2014 states the request for Oxycodone Hcl 20 #120/30/0 is denied as opiates are not recommended for long term use; Oxycontin 80 Mg # 180/30/0 is denied as guidelines do not support long term use of opioids; and Carisoprodol 350 Mg, # 90/30/0 is denied as there is no documented evidence of spasm and the patient has been recommended weaning in the past and was provided refills for that purpose. Progress report dated 02/19/2014 indicates the patient presented with complaints of chronic lumbar pain and leg pain. He reported the trial of Norco did not work as well and his quality of sleep is poor and averages 4-5 hours of interrupted sleep per night. He rated his pain as 8/10. On exam, he continued to have pain radiating to his legs. He has increased pain with sitting and standing. He is diagnosed with chronic severe low back

pain, falling/moving artificial disc at L5/S1; myofascial pain/spasm; unspecified myositis and myalgia. The patient was instructed to continue with medications including Zanaflex, Subsys, methadone, Cymbalta, Oxycontin 80 mg, Soma 350 mg, Norco 10/325 mg, Oxycodone 20 mg; and Lazanda 400 ugm. Prior utilization review dated 05/19/2014 states the request for Oxycodone Hcl 20 #120/30/0 is denied as opiates are not recommended for long term use; Oxycontin 80 Mg # 180/30/0 is denied as guidelines do not support long term use of opioids; and Carisoprodol 350 Mg, # 90/30/0 is denied as there is no documented evidence of spasm and the patient has been recommended weaning in the past and was provided refills for that purpose.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **OXYCODONE HCL 20 #120/30/0: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for Use of Opioids Page(s): 76-96. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain, Opioids.

**Decision rationale:** According to the Chronic Pain Medical Treatment Guidelines, Opioids are recommended as the standard of care for treatment of moderate to severe pain for short-term use. Supporting documents do not establish functional improvement and long-term use of opiates is not supported by current evidence based guidelines. This medication is not medically necessary. Medical Treatment Guidelines stipulates that the lowest possible dose of opioids be employed to improve pain and function. Here, however, the attending provider's documentation has failed to make a compelling case for provision of two separate short-acting opioids, Subsys and Oxycodone. Therefore, the request for Oxycodone HCL 20mg #120/30/0 is not medically necessary.

#### **OXYCONTIN 80 MG # 180/30/0: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for Use Of Opioids Page(s): 76-96. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain, Opioids.

**Decision rationale:** According to the Chronic Pain Medical Treatment Guidelines, Opioids are recommended as the standard of care for treatment of moderate to severe pain for a time- limited and failure to respond to a time-limited course of opioids has led to the suggestion of re-assessment and consideration of alternative therapy. There is no supporting documentation of progress therefore, the medication is not medically necessary.

**CARISOPRODOL 350 MG, # 90/30/0:** Upheld

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

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

**Decision rationale:** According to the Chronic Pain Medical Treatment Guidelines, Carisoprodol is not recommended for long-term use and abuse has been noted for sedative and relaxant effects. Current guidelines do not support the use of this medication therefore, it is not medically necessary.