

Case Number:	CM15-0011155		
Date Assigned:	01/29/2015	Date of Injury:	08/28/1994
Decision Date:	04/13/2015	UR Denial Date:	12/23/2014
Priority:	Standard	Application Received:	01/21/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 77 year old female who sustained an industrial injury on 08/28/1994. She complains of back pain. Diagnoses include chronic lower back pain, status post lumbosacral strain/sprain 08/28/1994, industrial aggravation of multilevel lumbar degenerative disc disease, status post a spinal cord stimulator trail, stroke with the left hemiplegia-non-industrial . Treatment to date has included medications. A physician progress note dated 12/19/2014 documents the injured worker has pain rated 6 out of 10 with medications, and 10 out of 10 without medications. She has moderate pain with medications. There is tenderness to palpation across the lower back. Neurologically she has left sided weakness with upper and lower extremities. She has a left hemiplegic gait. She is indicated to try intrathecal pain pump due to her memory impairment and high dose of pain medications. Treatment requested is for Carisoprodol 350mg tab Days' Supply 30 QTY: 60 Refills: 0, Lorazepam 1mg tab Days' Supply 30 QTY: 60 Refills: 0, OxyContin 60mg tab Days' Supply 25 QTY: 150 Refills: 0. On 12/23/2014 Utilization Review non-certified the request for Carisoprodol 350mg tab Days' Supply 30 QTY: 60 Refills: 0 and cited was California Medical Treatment Utilization Schedule (MTUS)-Chronic Pain Medical Treatment Guidelines. On 12/23/2014 Utilization Review non-certified the request for Lorazepam 1mg tab Days' Supply 30 QTY: 60 Refills: 0 and cited was California Medical Treatment Utilization Schedule (MTUS)-Chronic Pain Medical Treatment Guidelines. On 12/23/2014 Utilization Review non-certified the request for OxyContin 60mg tab Days' Supply 25 QTY: 150 Refills: 0 and cited was California Medical Treatment Utilization Schedule (MTUS)-Chronic Pain Medical Treatment Guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Oxycontin 60mg tab Days Supply 25 QTY: 150 Refills: 0: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Oxycodone Immediate release Page(s): 29.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CRITERIA FOR USE OF OPIOIDS Page(s): 76-78, 88-89.

Decision rationale: This patient presents with back pain. The treater has asked for OXYCONTIN 60MG TAB DAYS SUPPLY 25 QTY: 150 REFILLS 0 on 12/19/14. The patient has been taking Oxycontin since 3/10/14 report. For chronic opioids use, MTUS Guidelines pages 88 and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4As (analgesia, ADLs, adverse side effects, and adverse behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. In this case, the treater does not indicate a decrease in pain with current medications, stating oxycontin does not help her any more per 10/21/14 report. There is no discussion of this medications efficacy in terms of functional improvement using numerical scale or validated instrument. Quality of life change, or increase in specific activities of daily living are not discussed. There is no discussion of return to work or change in work status attributed to the use of the opiate. Urine toxicology has been asked for per 12/19/14 report, but no other aberrant behavior monitoring is provided such as CURES report. Given the lack of sufficient documentation regarding chronic opiates management as required by MTUS, a slow taper off the medication is recommended at this time. The request IS NOT medically necessary.

Carisoprodol 350mg tab Days Supply 30 QTY: 60 Refills: 0: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Soma Page(s): 29.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants carisoprodol Page(s): 63-66, 29.

Decision rationale: This patient presents with back pain. The treater has asked for CARISOPRODOL 350MG TAB DAYS SUPPLY 30 QTY: 60 REFILLS 0 on 12/19/14. Patient has been taking Soma since 3/10/14. Regarding Soma, MTUS does not recommend for longer than a 2 to 3 week period. Abuse has been noted for sedative and relaxant effects. In this case, the patient has been taking Soma for 7 months. MTUS recommends Soma for short term use only, for a maximum of 2-3 weeks. The requested Soma is not indicated per MTUS guidelines. The request IS NOT medically necessary.

Lorazepam 1mg tab Days Supply 30 QTY: 60 Refills: 0: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines benzodiazepines Page(s): 24.

Decision rationale: This patient presents with back pain. The treater has asked for LORAZEPAM 1MG TAB DAYS SUPPLY 30 QTY: 60 REFILLS 0 on 12/19/14. Patient has been taking Lorazepam since 3/10/14 report. Regarding benzodiazepines, MTUS recommends for a maximum of 4 weeks, as long-term efficacy is unproven and there is a risk of dependence. In this case, the patient has been taking Lorazepam for 7 months which exceeds MTUS guidelines. MTUS recommends benzodiazepines for short term use only, for a maximum of 4 weeks. The request IS NOT medically necessary.