

Case Number:	CM15-0190334		
Date Assigned:	10/02/2015	Date of Injury:	01/02/1996
Decision Date:	12/03/2015	UR Denial Date:	09/17/2015
Priority:	Standard	Application Received:	09/28/2015

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: Preventive Medicine, Occupational Medicine

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 68 year old female who sustained an industrial injury on 01/02/1996. A review of the medical records indicated that the injured worker is undergoing treatment for lumbar central canal stenosis, multi-level facet arthritis and spondylosis, multi-level disc protrusion and lumbar myofascial spasms. According to the treating physician's progress report on 08-26-2015, the injured worker continues to experience intermittent low back pain with mild weakness in both legs and intermittent numbness and tingling down towards the feet. Examination demonstrated severe limited lumbar range of motion especially with forward flexion and extension. Myofascial spasms in the L4 and L5 region were present on deep palpation. Positive facet loading was documented. Straight leg raise was positive bilaterally with decreased Achilles deep tendon reflexes at 2 out of 4 and symmetric. Numerous types and combinations of oral medications and non-surgical options have been used in the past without specifics noted. The injured worker has been on long term medications for pain. The injured worker would like to avoid surgical intervention. No diagnostic reports were included in the review. No urine drug screening reports were available. Treatment plan consists of her current medication regimen and the providers request for Lyrica 100mg #180 with 1 refill, Mobic 15mg #90 with no refills, OxyContin 10 mg 75mg #75-100 with no refills, Vicodin ES 7.5/300mg #180 with no refills. On 09-17-2015 the Utilization Review modified the request for Lyrica 100mg #180 with 1 refill to Lyrica 100mg #90 with 0 refill, Mobic 15mg #90 to Mobic 15mg #30 with 0 refills, OxyContin 10 mg #75-100 with no refills to OxyContin 10 mg #60 with 0 refills and Vicodin ES 7.5/300mg #180 with no refills to Vicodin ES 7.5/300mg #120 with 0 refills.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lyrice 100 MG #180 with 1 Refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antiepilepsy drugs (AEDs).

Decision rationale: The MTUS states that Lyrice has FDA approval for painful diabetic neuropathy, postherpetic neuralgia, and fibromyalgia. The patient is not diagnosed with the above indications. In addition, a recent review has indicated that there is insufficient evidence to recommend for or against antiepileptic drugs for axial low back pain. A previous utilization review decision provided the patient with sufficient quantity of medication to be weaned slowly. Lyrice 100 MG #180 with 1 refill is not medically necessary.

Mobic 15 MG #90 with No Refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steroidal anti-inflammatory drugs).

Decision rationale: The MTUS recommends NSAIDs at the lowest dose for the shortest period in patients with moderate to severe pain. NSAIDs appear to be superior to acetaminophen, particularly for patients with moderate to severe pain. There is no evidence of long-term effectiveness for pain or function. Guidelines recommend NSAIDs as an option for short-term symptomatic relief. Mobic 15 MG #90 with no refills is not medically necessary.

OxyContin 10 MG 75 MG #75-100 with No Refills: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain.

Decision rationale: Guidelines state that OxyContin is indicated for moderate to moderately severe pain. Guidelines further state the criteria for the use of opioids is the ongoing review and documentation of the patient's pain relief, functional status, appropriate medication use, and side effects. In this case, the medical necessity has been established for the patient's use of the requested OxyContin as a first-line analgesic agent for pain relief for the patient's treatment of

chronic pain as it is appropriate in this clinical setting. The original reviewer approved this request. OxyContin 10 MG 75 MG #75-100 with no refills is medically necessary.

Vicodin ES 7.5/300 MG #180 with No Refills: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain.

Decision rationale: Guidelines state that Vicodin ES is indicated for moderate to moderately severe pain. Guidelines further state the criteria for the use of opioids is the ongoing review and documentation of the patient's pain relief, functional status, appropriate medication use, and side effects. In this case, the medical necessity has been established for the patient's use of the requested Vicodin ES as a first-line analgesic agent for pain relief for the patient's treatment of chronic pain as it is appropriate in this clinical setting. The original reviewer approved this request. Vicodin ES 7.5/300 MG #180 with no refills is medically necessary.