

Case Number:	CM15-0028870		
Date Assigned:	03/27/2015	Date of Injury:	02/22/2000
Decision Date:	05/01/2015	UR Denial Date:	02/06/2015
Priority:	Standard	Application Received:	02/17/2015

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: New York
 Certification(s)/Specialty: Internal 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 71 year old female, who sustained an industrial injury on 2/22/00. The injured worker has complaints of low back pain with bilateral leg pain. The diagnoses have included low back pain, lumbar post-laminectomy syndrome; degeneration of lumbar intervertebral disc and chronic constipation. The documentation on 12/4/14 noted that the injured worker received radiofrequency ablations with the last one on 5/21/14 that took longer to be effective but had more than 75% relief of low back pain up until four weeks prior. Magnetic Resonance Imaging (MRI) of the lumbar on 3/15/12 shows a progression of degenerative changes since 2007, she has a multilevel degenerative disc disease with facet arthropathy, anterolisthesis with pars defect at L5-S1, foraminal stenosis at L5-S1 and L4-5. The requested treatment is for Retrospective general comprehensive pharmacy review for five medications between 1/18/14 and 1/20/15 that include carisoprodol, oxycodone, horizant, omeprazole and linzess.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective general comprehensive pharmacy review for five medications between 1/18/14 and 1/20/15: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CA MTUS: Opioids for the treatment of chronic pain, proton pump inhibitors, muscle relaxants, Anti-epileptic drugs (AEDs). Decision based on Non-MTUS Citation Official Disability Guidelines: Chronic Pain, Constipation.

Decision rationale: The documentation indicates that the claimant's provider participated in a peer to peer review of the claimant's medications history covering the period 1/18/14-1/20/15. The medical conditions and the treatment plans were reviewed. The conclusions indicated that the use of Oxycodone was certified as appropriate according to CA MTUS Guidelines for the use of opioids for the treatment of chronic pain. The medications, Soma, Horizant, Omeprazole and Linzess were not certified. Regarding Soma, it was determined that a muscle relaxant which causes less sedation and potential for abuse would be used short-term use for flares of pain. Regarding Horizant, there was no specific indication for the use of an extended release formulation of Gabapentin over generic, and there was no specific indication for the use of Omeprazole for gastric protection. Linzess is indicated for the treatment of irritable bowel syndrome with predominate constipation and for idiopathic constipation. There was no documentation of the use of other generic medication treatments for constipation presumed related to opiate use. There is no indication for any further retrospective general pharmacy review for the medications. Medical necessity for the requested item is not established. The requested item is not medically necessary.