

Case Number:	CM15-0040107		
Date Assigned:	03/10/2015	Date of Injury:	05/07/2001
Decision Date:	04/14/2015	UR Denial Date:	02/13/2015
Priority:	Standard	Application Received:	03/03/2015

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 61 year old female who sustained an industrial injury on May 7, 2001. She has reported low back pain and has been diagnosed with lumbosacral spine disc syndrome with strain/sprain disorder, radiculopathy, status post laminectomy discectomy surgical procedure, postoperative laminectomy discectomy syndrome, status post placement of dorsal spinal electrical stimulation unit, and chronic pain syndrome with idiopathic insomnia. Treatment has included surgery and medications. Currently the injured worker had reduced range of motion of the lumbosacral spine in all planes, reduced bilateral straight leg raising measurement, reduced sensation and strength in the distribution of the right S1 spinal nerve root, and tender right lumbosacral paraspinal muscular spasms. The treatment plan included medication management.

IMR ISSUES, DECISIONS AND RATIONALES

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

Oxycontin 80mg #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for the treatment of chronic pain Page(s): 91-97.

Decision rationale: According to MTUS, Oxycontin is a long-acting opioid analgesic indicated for moderate to severe pain, and is used to manage both acute and chronic pain. The treatment of chronic pain with any opioid analgesic requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. A pain assessment should include current pain, intensity of pain after taking the opiate, and the duration of pain relief. In this case, there is no documentation of this medication's pain relief effectiveness, functional status, or response to ongoing opioid analgesic therapy. Based on prior reviews, this patient should have already been completely weaned from this medication. Medical necessity of the requested item has not been established. Medical necessity for the requested item has not been established. The requested item is not medically necessary.

Anaprox DS 550mg #30 with 5 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines non-steroidal anti-inflammatory drugs (NSAIDs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67.

Decision rationale: Anaprox is a non-steroidal anti-inflammatory medication (NSAID). These types of medications are recommended for the treatment of chronic pain as a second line of therapy after acetaminophen. The documentation indicates the patient has been maintained on the medication since prior to 11/24/14 and there has been no compelling evidence presented by the provider to document that the patient has had any significant improvements from this medication. Medical necessity for the requested treatment has not been established. The requested treatment is not medically necessary.