

Case Number:	CM14-0109330		
Date Assigned:	09/16/2014	Date of Injury:	09/20/1988
Decision Date:	10/15/2014	UR Denial Date:	06/26/2014
Priority:	Standard	Application Received:	07/14/2014

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 Preventative Medicine, has a subspecialty in Occupational Medicine and is licensed to practice in Iowa. 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:

This injured worker is a 53 year old employee with date of injury of 9/20/1988. Medical records indicate the patient is undergoing treatment for status post L4-L5 laminectomy, 1989; L4 through S1 surgery, 2003; and spinal cord stimulator, 2007. Subjective complaints include complaints by the patient that he foot "skips" on occasion when he walks a mile or so. He thinks he has foot drop. He complains of numbness and tingling from the waist down with L4, L5 and L5-S1 being painful. He says the tingling goes to his head. Objective findings include per EMG there is non-radicular lumbago, no evidence of neurological radiculopathy and no foot drop. His tibialis anterior is 5/5 bilaterally and he can heel/toe rise. When the physician asked the patient to point out where L4, L5 and L5-S1 hurt, the patient pointed to his back. When asked where the numbness occurs, he pointed to his foot. Sensory exam is normal and there is no palpable fluctuance or muscle wasting. Motor strength is 5/5. His reflexes are symmetric. On exam, he presents with excellent solid arthrodesis with no hardware failure or osteolysis. Treatment has consisted of Oxycodone, Carisoprodol and a medial branch block and facet injection (7/19/2011). The utilization review determination was rendered on 6/26/2014 recommending non-certification of Oxycodone 10-325mg #240 and Carisoprodol 350mg #60.

IMR ISSUES, DECISIONS AND RATIONALES

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

Oxycodone 10-325mg #240: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
Page(s): Page 81.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids
Page(s): 74-96. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)
Low Back - Lumbar & Thoracic (Acute & Chronic), Opioids

Decision rationale: Oxycodone is the generic version of OxyContin, which is a pure opioid agonist. Official Disability Guidelines (ODG) does not recommend the use of opioids for low back pain "except for short use for severe cases, not to exceed 2 weeks." The patient has exceeded the 2 week recommended treatment length for opioid usage. MTUS does not discourage use of opioids past 2 weeks, but does state that "ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life." The treating physician does not fully document the least reported pain over the period since last assessment, intensity of pain after taking opioid, pain relief, increased level of function, or improved quality of life. As such, the request for Oxycodone 10-325mg #240 is not medically necessary.

Carisoprodol 350mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Page(s): 29. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain, Soma (Carisoprodol)

Decision rationale: MTUS states "Not recommended. This medication is not indicated for long-term use. Carisoprodol is a commonly prescribed, centrally acting skeletal muscle relaxant whose primary active metabolite is meprobamate (a schedule-IV controlled substance). Carisoprodol is now scheduled in several states but not on a federal level. It has been suggested that the main effect is due to generalized sedation and treatment of anxiety. Abuse has been noted for sedative and relaxant effects. In regular abusers the main concern is the accumulation of meprobamate. Carisoprodol abuse has also been noted in order to augment or alter effects of other drugs." Official Disability Guidelines (ODG) states that Soma is "Not recommended. This medication is FDA-approved for symptomatic relief of discomfort associated with acute pain in musculoskeletal conditions as an adjunct to rest and physical therapy (AHFS, 2008). This medication is not indicated for long-term use." The patient has been on the medication for two years well in excess of guideline recommendations. In addition, the treating physician does not provide evidence of functional improvement, decrease in symptoms, or improved quality of life. As such, the request for Carisoprodol 350mg #60 is not medically necessary.

