

<b>Case Number:</b>	CM14-0091551		
<b>Date Assigned:</b>	07/25/2014	<b>Date of Injury:</b>	03/03/2004
<b>Decision Date:</b>	09/25/2014	<b>UR Denial Date:</b>	06/09/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/17/2014

### 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 Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in Texas. 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:

The injured worker is a 53 year old male injured on 03/03/04 while lifting cartons from a pallet resulting in low back pain radiating to the bilateral lower extremities. The clinical note dated 05/19/14 indicated the injured worker presented complaining of low back pain radiating to the bilateral lower extremities aggravated by activity and walking. The injured worker also complained of frequent muscle spasms in the low back bilaterally, ongoing headaches, insomnia, and tooth decay. The injured worker rated the pain at 7/10 with medications and 8/10 without. The injured worker reported the use of current medications was helpful. Physical examination of the lumbar spine revealed spasm, tenderness upon palpation of the spinal vertebral area at L2-S1, moderately limited range of motion due to pain, tenderness to bilateral knees, decreased range of motion, and decreased strength along the L4-S1 dermatome and bilateral lower extremities. Diagnoses include lumbar disc degeneration, chronic pain, failed back surgery syndrome, lumbar radiculopathy, bilateral knee pain, and iatrogenic opioid dependency. The documentation indicated prior weaning of opioid medications had been unsuccessful and pain severely worsened with reduction of function and activities of daily living. Medications included Cymbalta, Gabapentin, Oxycontin, Percocet, Restone, Senna, and Orphenadrine. The initial request for Oxycontin, Orphenadrine, and Percocet was initially non-certified on 06/09/14.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Oxycontin 20mg Qty 60:** 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 Criteria for Use of Opioids Page(s): 77.

**Decision rationale:** As noted on page 77 of the Chronic Pain Medical Treatment Guidelines, patients must demonstrate functional improvement in addition to appropriate documentation of ongoing pain relief to warrant the continued use of narcotic medications. There is no clear documentation regarding the functional benefits or any substantial functional improvement obtained with the continued use of narcotic medications. Specific examples of improved functionality should be provided to include individual activities of daily living, community activities, and exercise able to perform as a result of medication use. As such Oxycontin 20mg Qty 60 cannot be recommended as medically necessary at this time.

**Orphenadrine citrate extended release Qty 120:** 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 9792.20, Muscle relaxants (for pain) Page(s): 63.

**Decision rationale:** As noted on page 63 of the Chronic Pain Medical Treatment Guidelines, muscle relaxants are recommended as a second-line option for short-term (less than two weeks) treatment of acute low back pain and for short-term treatment of acute exacerbations in patients with chronic low back pain. Studies have shown that the efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. Based on the clinical documentation, the injured worker has exceeded the 2-4 week window for acute management also indicating a lack of efficacy if being utilized for chronic flare-ups. As such, the medical necessity of Orphenadrine citrate extended release Qty 120 cannot be established at this time.

**Percocet 10/325mg Qty 120:** 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 Criteria for Use of Opioids Page(s): 77.

**Decision rationale:** As noted on page 77 of the Chronic Pain Medical Treatment Guidelines, patients must demonstrate functional improvement in addition to appropriate documentation of ongoing pain relief to warrant the continued use of narcotic medications. There is no clear documentation regarding the functional benefits or any substantial functional improvement obtained with the continued use of narcotic medications. Specific examples of improved

functionality should be provided to include individual activities of daily living, community activities, and exercise able to perform as a result of medication use. As such Percocet 10/325mg Qty 120 cannot be recommended as medically necessary at this time.