

<b>Case Number:</b>	CM14-0099199		
<b>Date Assigned:</b>	07/28/2014	<b>Date of Injury:</b>	05/06/2009
<b>Decision Date:</b>	10/20/2014	<b>UR Denial Date:</b>	06/07/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/27/2014

### 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 Physical Medicine & Rehabilitation and Pain Medicine and is licensed to practice in Oklahoma. 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 52-year-old male who reported an injury on 05/06/2009. The mechanism of injury was not provided within the medical records. The clinical note dated 05/19/2014 indicated diagnoses of right elbow internal derangement, right elbow pain, right elbow contusion, right knee internal derangement, status post right knee surgery, right knee meniscal tear, right paracentral disc protrusion at L5-S1, lumbar degenerative disc disease, lumbar facet joint arthropathy, low back pain, lumbar sprain/strain, right knee sprain/strain, right elbow sprain/strain. The injured worker reported bilateral low back pain, right elbow pain, and right knee pain. The injured worker reported new acute lumbar spasms, exacerbating factors were any activities, mitigating factor was pain medication. On physical examination, there was tenderness upon palpation of the right elbow, right knee, and lumbar paraspinal muscles. The injured worker's lumbar, thoracic, right elbow and right knee range of motion were restricted by pain in all directions. The injured worker's lumbar, discogenic, thoracic, right elbow and right knee provocative maneuvers were positive. The injured worker's lumbar spasms were positive. The injured worker's nerve root tension signs were negative bilaterally. The injured worker ambulated with an antalgic gait and used a cane. The injured worker's treatment plan included follow-up visit in 4 weeks. The injured worker's prior treatment included diagnostic imaging, surgery, and medication management. The injured worker's medication regimen included Oxycontin and Soma. The provider submitted a request for Oxycontin and Soma. A Request for Authorization was not submitted for review to include the date the treatment was requested.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Oxycodone 10/325mg, #120 with 0 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-going Management Page(s): 78.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for Use, On-going Management, Page(s): , page 78..

**Decision rationale:** The request for Oxycodone 10/325mg, #120 with 0 refills is not medically necessary. The California MTUS Guidelines recommend the use of opioids for the on-going management of chronic low back pain. The ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should be evident. The medical records provided indicate the injured worker's Oxycodone provided 40% pain relief and improvement in activities of daily living with no side effects. It was noted a urine drug screen performed 04/07/2014 was inconsistent and revealed the absence of oxycodone and the presence of hydrocodone. While the medication may provide pain relief and functional improvement, there is a lack of documentation regarding appropriate medication use. In addition, the submitted request does not specify a frequency. Based on this information, the request is not supported. As such, the request for Oxycodone 10/325mg, #120 with 0 refills is not medically necessary.

**OxyContin 60mg, #90 with 0 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-going Management Page(s): 78.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for Use, On-going Management Page(s): 78.

**Decision rationale:** The request for OxyContin 60mg #90 w/ 0 refill(s) is not medically necessary. The California MTUS Guidelines recommend the use of opioids for the on-going management of chronic low back pain. The ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should be evident. There is lack of significant evidence of an objective assessment of the injured worker's pain level, functional status, and evaluation of risk for aberrant drug use, behaviors, and side effects. Furthermore, the request does not indicate a frequency. Therefore, the request for OxyContin 60mg #90 w/ 0 refill(s) is not medically necessary.

**Soma 350mg #60 w/ 1 refill(s):** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Soma (Carisoprodol) Page(s): 29.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol (Soma), Page(s): 29.

**Decision rationale:** The request for Soma 350mg #60 w/ 1 refill(s) is not medically necessary. The California MTUS states that Soma (Carisoprodol) is not indicated for longer than a 2 to 3 week period. Carisoprodol is a commonly prescribed, centrally acting skeletal muscle relaxant. It was not indicated how long the injured worker had been utilizing the Soma. In addition, there is lack of documentation of efficacy and functional improvement with the use of Soma. Furthermore, the request does not indicate a frequency. Therefore, the request for Soma 350mg #60 w/ 1 refill(s) is not medically necessary.