

Case Number:	CM14-0037341		
Date Assigned:	06/25/2014	Date of Injury:	11/02/1990
Decision Date:	02/16/2015	UR Denial Date:	03/17/2014
Priority:	Standard	Application Received:	03/27/2014

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 Rehab, has a subspecialty in Pain Medicine, and is licensed to practice in California. 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 55-year-old female who reported an injury on 11/02/1990. The mechanism of injury was unspecified. Her diagnoses include lumbar degenerative disc disease, lumbar radiculopathy, sacroilitis, osteopenia, chronic lumbar pain, insomnia due to pain, and chronic therapeutic use of opioids. Her past treatments include medication, injection, and pain management. On 03/27/2014, the injured worker complained of low back pain rated 8/10 and leg pain rated 7/10. The physical examination revealed tenderness over the lower lumbar and upper sacral area along with moderate tenderness over the PSIS bilaterally. The injured worker was indicated to be positive with the SI joint testing on the right and sheer testing with resisted abduction and positive fabere test bilaterally. The injured worker also is indicated to have decreased sensation and deep tendon reflexes. Her current medications include oxycodone liquid 20 mg, Soma 350 mg, Ambien 12.5 mg, and Gralise 600 mg. The treatment plan included liquid oxycodone 180 mL for weaning, Ambien CR 12.5 mg #30, and some 350 mg #30. A rationale was not provided. A Request for Authorization form was not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Liquid Oxycodone 180 ml.: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines On-Going Management Page(s): 78.

Decision rationale: The request for liquid Oxycodone 180 ml is not medically necessary. According to the California MTUS Guidelines, chronic patients on opioids should have documentation in regard to pain relief, side effects, physical and psychosocial functioning, and evidence of any potentially aberrant drug related behaviors. The injured worker was indicated to have been on liquid Oxycodone since at least 02/27/2014. However, there is lack of objective functional improvement, objective functional decrease in pain, and evidence of monitoring for aberrant drug related behaviors and side effects. In addition, the documentation failed to provide a recent urine drug screen for review. However, the guidelines recommend a weaning schedule for opioid medications. Based on the above, the request is not supported by the evidence based guidelines. As such, the request is not medically necessary.

Ambien CR 12.5 mg. # 30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for pain) Page(s): 63-65.

Decision rationale: The request for Ambien CR 12.5 mg #30 is not medically necessary. According to the California MTUS Guidelines, they recommend nonsedating muscle relaxants with caution as a second line option for short term treatment of acute exacerbations in patients with chronic low back pain. In addition, the guidelines indicate that there have been no benefits shown beyond NSAIDs for pain and overall improvement. The injured worker was indicated to have been on Ambien for an unspecified duration of time. However, the guidelines indicate the use of Ambien for short term treatments of acute exacerbation in patients with chronic low back pain as a second line option. There was lack of documentation to indicate the duration of time the injured worker has been on Ambien. Based on the guidelines not recommending use for long term treatments of chronic low back pain, the request is not supported by the evidence based guidelines. As such, the request is not medically necessary.

Soma 350 mg. # 30: Upheld

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

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

Decision rationale: The request for Soma 350 mg #30 is not medically necessary. The California MTUS Guidelines do not recommend the use of Soma. Additionally, guidelines also state it is not indicated for long term use. The injured worker was noted to have been on Soma for an unspecified duration of time. However, the guidelines do not recommend the use of Soma,

nor is it indicated for long term use. In addition, the guidelines recommend a weaning schedule for muscle relaxant medications. Based on the above, the request is not supported by the evidence based guidelines. As such, the request is not medically necessary.