

Case Number:	CM15-0071467		
Date Assigned:	04/21/2015	Date of Injury:	04/03/2002
Decision Date:	05/20/2015	UR Denial Date:	03/30/2015
Priority:	Standard	Application Received:	04/15/2015

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: Massachusetts

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 49 year old man sustained an industrial injury on 4/3/2002. The mechanism of injury is not detailed. Evaluations include lumbar spine x-rays dates 5/13/2013 and 3/29/2013. Diagnoses include lumbar spine degenerative disc disease, chronic low back pain, and left sciatic pain. Treatment has included oral and topical medications, physical therapy, work hardening, exercise program, and surgical intervention. Physician notes dated 9/11/2014 show complaints of increased back pain with radicular symptoms in the bilateral lower extremities rated 4-8/10. Recommendations include lumbar spine x-rays, possible lumbar spine MRI pending x-ray results, continue current medications regimen, and follow up in one month.

IMR ISSUES, DECISIONS AND RATIONALES

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

Nortriptyline 10mg capsule unspecified quantity: Overturned

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 Antidepressants for Chronic Pain Page(s): 13-15.

Decision rationale: The claimant has a remote history of a work injury occurring in April 2002 and continues to be treated for low back pain with bilateral lower extremity radicular symptoms. When seen, medications are referenced as necessary in helping the claimants back pain and allowing him to continue functioning as an equipment manager. Medications are referenced as decreasing pain from 8/10 to 4/10. Nortriptyline was being prescribed. Medications included Percocet being prescribed at a total MED (Morphine equivalent dose) of 60 mg per day. Antidepressant medication is recommended as a first line option for neuropathic pain, and as a possibility for non-neuropathic pain. Tricyclics such as Nortriptyline are considered a first-line agent. Therefore, Nortriptyline was medically necessary.

Carisoprodol 350mg tablet unspecified quantity: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter Carisoprodol (Soma).

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

Decision rationale: The claimant has a remote history of a work injury occurring in April 2002 and continues to be treated for low back pain with bilateral lower extremity radicular symptoms. When seen, medications are referenced as necessary in helping the claimants back pain and allowing him to continue functioning as an equipment manager. Medications are referenced as decreasing pain from 8/10 to 4/10. Nortriptyline was being prescribed. Medications included Percocet being prescribed at a total MED (morphine equivalent dose) of 60 mg per day. Soma (Carisoprodol) is a muscle relaxant which is not recommended and not indicated for long-term use. Meprobamate is its primary active metabolite and the Drug Enforcement Administration placed Carisoprodol into Schedule IV in January 2012. It has been suggested that the main effect is due to generalized sedation and treatment of anxiety, and abuse has been noted for its sedative and relaxant effects. Prescribing Soma was not medically necessary.

Endocet 10/325mg tablet, unspecified quantity: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use; Opioids for chronic pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain Outcomes and Endpoints, Opioids, criteria for use, Opioids, dosing Page(s): 8, 76-80 and 86.

Decision rationale: The claimant has a remote history of a work injury occurring in April 2002 and continues to be treated for low back pain with bilateral lower extremity radicular symptoms. When seen, medications are referenced as necessary in helping the claimants back pain and allowing him to continue functioning as an equipment manager. Medications are referenced as decreasing pain from 8/10 to 4/10. Nortriptyline was being prescribed. Medications included Percocet being prescribed at a total MED (morphine equivalent dose) of 60 mg per day.

Guidelines indicate that when prescribing controlled substances for pain, satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. In this case, there are no identified issues of abuse or addiction and the claimant's medications are providing partial pain relief. Percocet is referenced as allowing continued activities including work. The total MED (morphine equivalent dose) is less than 120 mg per day. Therefore, the continued prescribing of Endocet was medically necessary.