

Case Number:	CM13-0027603		
Date Assigned:	04/18/2014	Date of Injury:	05/19/2010
Decision Date:	05/29/2014	UR Denial Date:	07/10/2013
Priority:	Standard	Application Received:	09/23/2013

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 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 patient is an employee of [REDACTED] and has submitted a claim for cervical myofascial pain and lumbar radiculopathy associated with an industrial injury on May 19, 2010. Treatment to date includes oral analgesics, muscle relaxants, and lumbar Final Determination Letter for IMR Case Number CM13-0027603 3 surgery. Utilization review dated July 9, 2013 denied request for diclofenac sodium due to no documentation of benefit; and carisoprodol because it is not indicated for chronic use, Reasons for denial of temazepam, hydrocodone/APAP and gabapentin were not made available. Medical records from 2013 to 2014 were reviewed and showed persistent complaints of neck and back pain with intermittent pain down to the left leg. Patient's symptoms are manageable with activity modification and the adjunct of her medications, however did not identify which of the medications provided relief. Physical examination showed tenderness in the lower paravertebral musculature. Forward flexion is 60 degrees, extension 10 degrees, lateral bending 30 degrees. Strength in the lower extremities is globally intact. Cervical spine forwardflexion is to within 1 fingerbreadth of chin to chest, extension 20 degrees, lateral rotation 60 degrees. She is taking Voltaren 75mg BID, Soma 350mg qhs, Neurontin 100mg 2 TID, Restoril 15mg qhs and Norco 10/325mg BID. Duration and frequency of intake were not mentioned.

IMR ISSUES, DECISIONS AND RATIONALES

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

RETROSPECTIVE DICLOFENAC SODIUM: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

Decision rationale: As stated on pages 67-68 of the California MTUS Chronic Pain Medical Treatment Guidelines, NSAIDs are useful in treating breakthrough and mixed pain conditions such as neuropathic pain, osteoarthritis, and back pain; there is no evidence for long-term effectiveness for pain and function. In this case, the patient has been taking Diclofenac (Voltaren) since March 2013, however duration and frequency of intake were not specified. The patient has chronic pain and states that medications help. Specific functional improvements from the use of this medication were not indicated such as increased ability to perform activities of daily living or increased work functions. There was no discussion regarding the indication for the use of diclofenac. Moreover, the request did not specify the dosage and amount of medication to dispense. Given no extenuating circumstances to continue the use of this medication, the request for diclofenac sodium is not medically necessary.

RETROSPECTIVE TEMAZEPAM: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 24.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.24.2 Page(s): 66-68.

Decision rationale: Temazepam is a benzodiazepine, a drug class for muscle relaxants. According to CA MTUS Chronic Pain Medical Treatment Guidelines page 68, benzodiazepines are not recommended due to rapid development of tolerance and dependence. There appears to be little benefit for the use of this class of drugs over nonbenzodiazepines for the treatment of spasm. It is not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. In this case, the patient has been taking temazepam (Restoril) since March 2013, however duration and frequency of intake were not specified. The request did not specify the dosage and amount of medication to dispense. There is no evidence that temazepam is for short-term use only. Long-term use is not recommended. Therefore, the request for temazepam is not medically necessary.

RETROSPECTIVE CARISOPRODOL: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 Page(s): 29.

Decision rationale: As stated in page 29 of CA MTUS Chronic Pain Medical Treatment Guidelines, carisoprodol (Soma) is a centrally acting skeletal muscle relaxant that is not

indicated for long-term use. Carisoprodol abuse has been noted in order to augment or alter effects of other drugs such as hydrocodone, tramadol, benzodiazepine and codeine. In this case, the patient has been taking carisoprodol since March 2013 however duration and frequency of intake were not specified. Medical records submitted and reviewed indicate that this medication is being taken together with hydrocodone/acetaminophen (Norco) which is not recommended per the guidelines due to high potential of abuse. It is not recommended for long-term use. Moreover, the request did not specify the dosage and amount of medication to dispense. Therefore, the request for prescription of carisoprodol is not medically necessary.

RETROSPECTIVE HYDROCODONE/APAP: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.24.2 Page(s): 79-81.

Decision rationale: As noted on page 79-81 of the Chronic Pain Medical Treatment Guidelines, there is no support for ongoing opioid treatment unless there is ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. In this case, the patient has been taking hydrocodone/APAP (Norco) as far back as 2013 however duration and frequency of Final Determination Letter for IMR Case Number CM13-0027603 5 intake were not specified. Specific functional improvements from the use of this medication were not indicated such as increased ability to perform activities of daily living or increased work functions. There was no discussion regarding the indication for the use of hydrocodone/APAP. Moreover, the request did not specify the dosage and amount of medication to dispense. Given no extenuating circumstances to continue the use of this medication, the request for hydrocodone/APAP is not medically necessary.

RETROSPECTIVE GABAPENTIN: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 49.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.24.2, Page(s): 16-17.

Decision rationale: As stated on page 16-17 of the California MTUS Chronic Pain Medical Treatment Guidelines, gabapentin has been considered as a first-line treatment for neuropathic pain. After initiation of treatment there should be documentation of pain relief and improvement in function as well as documentation of side effects incurred with use. The continued use of AEDs depends on improved outcomes versus tolerability of adverse effects. In this case, the patient has been using gabapentin (Neurontin) since March 2013 however duration and frequency of use were not specified. Moreover, the request did not specify the dosage and amount of medication to dispense. Continued use of gabapentin is not recommended as specific functional gains or analgesia were not documented such as improved ability to perform activities

of daily living. There is no discussion concerning the need for variance from the guidelines. Therefore, the request for gabapentin is not medically necessary.