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| <b>Case Number:</b>   | CM13-0049658 |                              |            |
| <b>Date Assigned:</b> | 12/27/2013   | <b>Date of Injury:</b>       | 04/08/2002 |
| <b>Decision Date:</b> | 03/06/2014   | <b>UR Denial Date:</b>       | 10/07/2013 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 11/08/2013 |

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Anesthesiology, has a subspecialty in Pain Management, and is licensed to practice in Florida. 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 physician 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 a 57-year-old who reported injury on 04/08/2002. The mechanism of injury was not provided. The patient was noted to have low back pain radiating to the right lower extremity to the level of the foot and toes. The back pain was noted to be associated with tingling and numbness in the lower extremity. The patient's pain level was noted to be an average of 8/10 with medications and 10/10 without medications. The patient was noted to have spinal vertebral tenderness in the lumbar spine at the L4-S1 level. The patient was noted to have lumbar myofascial tenderness and paraspinal muscle spasm on palpation. The patient was noted to be in the office for medication refills.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Carisoprodol 350mg, 90 count:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63.

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines indicate that muscle relaxants are a second line short term therapy for acute exacerbations for chronic pain and are

indicated for no more than 2 weeks to 3 weeks. The clinical documentation submitted for review indicated the patient had been taking the medication for greater than 3 weeks. There was a lack of documentation of the efficacy of the requested medication. The request for Carisoprodol 350mg, 90 count, is not medically necessary or appropriate.

**Tramadol ER 150mg, 30 count:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 60 and 78..

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines indicate that, for continuation on opiates, there should be documentation of an objective decrease in the visual analog scale, objective functional improvement, documentation of adverse side effects, and documentation of aberrant drug behavior. The clinical documentation submitted for review failed to meet the above criteria. The request for Tramadol ER 150mg, 30 count, is not medically necessary or appropriate.

**Desyrel 50mg, 30 count:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**Decision rationale:** Official Disability Guidelines recommend trazodone for insomnia; however, there is less evidence to support their use for insomnia, but they may be an option in patients with co-existing depression. The clinical documentation submitted for review failed to indicate the efficacy of the requested medication. Additionally, it failed to provide the patient had a documentation of co-existing depression. The request for Desyrel 50mg, 30 count, is not medically necessary or appropriate.