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| Case Number: | CM13-0050293 | | |
| Date Assigned: | 12/27/2013 | Date of Injury: | 01/16/2003 |
| Decision Date: | 06/03/2014 | UR Denial Date: | 10/10/2013 |
| Priority: | Standard | Application Received: | 11/11/2013 |

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 Anesthesiology has a subspecialty in Pain Management 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 has filed a claim for chronic pain syndrome associated with an industrial injury date of January 16, 2003. Thus far, the patient has been treated with physical therapy, acupuncture, cervical facet blocks, cervical collar, lumbar brace, epidural steroid injection, trigger point injections to cervical and lumbar area, opiates, Fiorinal, muscle relaxants, Cymbalta, NSAIDs, omeprazole, and Soma. Patient has had multiple cervical and lumbar fusion surgeries and left shoulder arthroscopy. Review of progress notes shows worsening headache, neck pain radiating to right upper extremity, and low back pain radiating to bilateral lower extremities. There are limitations in activities of daily living with regards to self-care and hygiene, activity, ambulation, hand function, and sleep. Findings include cervical and lumbar spinal tenderness with limited range of motion due to pain, cervical muscle spasm, decreased sensation of the left C6-7 distribution, and positive straight leg raise test bilaterally at the L3-4 and S1 distributions. Cervical MRI dated January 16, 2013 showed stable post-fusion changes, multilevel disc protrusions, degenerative changes, and multilevel neuroforaminal narrowing. Lumbar MRI dated January 25, 2013 showed stable post-fusion changes, degenerative central stenosis, and multilevel disc extrusion with neuroforaminal narrowing. Utilization review dated October 10, 2013 indicates that the claims administrator denied the requests for carisoprodol 350mg as it is not recommended and there is no documentation of objective functional benefit from this medication; Fioricet as this medication is not recommended and may cause rebound headaches; Beck Depression Inventory screening evaluation as there is no documentation that supports the presence of depression in this patient; and urine drug screen as the requesting physician and the prescribing physician are not the same persons.

IMR ISSUES, DECISIONS AND RATIONALES

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

CARISOPRODOL 350MG, NO FREQUENCY: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 29, 65.

Decision rationale: Pages 29 and 65 of CA MTUS Chronic Pain Medical Treatment Guidelines state that SOMA is not recommended. Carisoprodol is a centrally acting muscle relaxant metabolized to meprobamate an anxiolytic that is a schedule IV controlled substance. This is not recommended for long-term use. Patient has been on this medication since at least May 2013. There is no documentation regarding functional benefits derived from this medication. Therefore, the request for carisoprodol 350mg, no frequency is not medically necessary and appropriate.

FLORICET TAB, BID-TID PRN: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Barbiturate-Containing Analgesic Agents (BCAs), Page(s): 23, 80.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 23.

Decision rationale: Fioricet contains butalbital, acetaminophen, and caffeine. MTUS Chronic Pain Medical Treatment Guidelines state that barbiturate-containing analgesics are not recommended for chronic pain, with high potential for drug dependence and no evidence to show a clinically important enhancement of analgesic efficacy of BCAs due to the barbiturate constituents. There is a risk of medication overuse and rebound headaches. Patient has been on Fiorinal since November 2012. There is prescription for Fioricet in August 2013 but later progress reports indicate Fiorinal as the prescribed medication. There is no clear indication that this medication provides significant improvement for the patient's headaches. In addition, this medication is not recommended for patient's chronic pain and may even bring about rebound headaches. The requested quantity is not specified as well. Therefore, the request for Fioricet tab bid-tid prn is not medically necessary and appropriate.

**REQUEST FOR BECK DEPRESSION INVENTORY SCREENING EVALUATION:
Upheld**

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.minddisorders.com/A-BriBeck-Depression-Inventory.html>.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 100-101.

Decision rationale: Pages 100-101 of CA MTUS Chronic Pain Medical Treatment Guidelines states that psychological evaluations are recommended and are generally accepted, well-established diagnostic procedures not only with selected use in pain problems, but also with more widespread use in chronic pain populations. The Beck Depression Inventory assesses intensity of depression. In this case, there is no documentation of depression symptoms in this patient. Although patient's diagnoses include anxiety and depression, there is no description of symptoms or psychological reports to support these diagnoses. There is no clear indication for the necessity of this screening evaluation at this time. Therefore, the request for Beck Depression Inventory Screening Evaluation is not medically necessary per the guideline recommendations of MTUS.

REQUEST FOR URINE DRUG SCREEN: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) On-Line <http://www.odg-twc.com/odgtwc/pain.htm>.

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

Decision rationale: As stated on page 78 of the California MTUS Chronic Pain Medical Treatment Guidelines, urine drug screens are recommended as an option to assess order use or presence of illegal drugs and as ongoing management for continued opioid use. In this case, patient had been on opioid therapy since at least November 2012 and there is no documentation of periodic urine drug screening to monitor medication use. A urine drug screen is reasonable at this time for ongoing opioid therapy. Therefore, the request for urine drug screen is medically necessary and appropriate.