

Case Number:	CM13-0061293		
Date Assigned:	12/30/2013	Date of Injury:	06/04/2001
Decision Date:	04/11/2014	UR Denial Date:	11/22/2013
Priority:	Standard	Application Received:	12/04/2013

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 and Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Texas. 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 a 39-year-old male who reported an injury on 06/04/2001. The patient has been seen for ongoing complaints of lower back pain and in 10/2013, had undergone an open revision of the distal clavicle excision, in addition to revision of a subacromial decompression and arthroscopic lysis of adhesions in his left shoulder. The patient was seen most recently on 11/14/2013 where upon it was noted that his recent urine collection was positive for Dilaudid which had been given to him intraoperatively and/or postoperatively in the recovery room. The patient is also status post laminectomy and microdiscectomy in his head and anterior approach of the L5-S1 disc replacement surgery. The patient has constant left lower extremity radicular pain going back to before the back surgeries. The patient stated the pain that goes down to the left lower extremity has actually worsened after his back surgeries. On the physical examination, the patient had exquisite tenderness over the scar in his lumbar region, with palpable muscle spasms next to the scar. There is also worsening pain with posterior extension and range of motion in the low back which had decreased. In the left lower extremity, the patient's deep tendon reflexes were 2+/2 in both knees, but decreased or absent in both ankles. The patient also had positive straight leg raise on the left lower extremity with sensory decreased in the left lateral leg with no gross motor deficit.

IMR ISSUES, DECISIONS AND RATIONALES

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

SOMA 340MG #90: Upheld

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

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

Decision rationale: According to Chronic Pain Medical Treatment Guidelines, Carisoprodol is not recommended and not indicated for long-term use. Although the patient has had ongoing chronic low back pain, as well as recent left shoulder pain due to a surgical procedure, there are no quantitative/objective measurements of the patient's pain scale to indicate this medication has been effective in treating the patient's chronic pain. Furthermore, with the medication not recommended under California MTUS Guidelines, the continuation of its use cannot be supported. As such, the requested service is not medically necessary.

ALPRAZOLAM 0.5MG #45: Upheld

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

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

Decision rationale: This medication belongs to a group of drugs called Benzodiazepines. It is used to treat anxiety disorders, panic disorders, and anxiety caused by depression. Under California MTUS Guidelines, Benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there is risk of dependence. ████████ did not clarify the medical necessity or provide a thorough rationale for the use of the Alprazolam. The recent documentation does not provide any information indicating this patient has any kind of anxiety or panic disorders caused by depression. Therefore, without having a thorough rationale for the use of this medication and with the non-recommendation of use under Chronic Pain Medical Treatment guidelines, the requested service cannot be supported. As such, the requested service is not medically necessary.

NORCO 10/325MG #240: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96.

Decision rationale: Chronic Pain Medical Treatment Guidelines, it states Opioid tolerance develops with repeated use of Opioids and brings about the need to increase the dose and may lead to sensitization. It further states that analgesia is not always sustained over time and that pain may be improved with weaning of Opioids. Although the documentation does indicate the patient is being requested for a spinal cord stimulator and the medications reportedly helped to

increase his level of function and daily activities, the most recent documentation dated 10/17/2013 and 11/14/2013 state the patient's pain on average is 7/10 and can as severe as 8/10 to 9/10. Therefore, it is unclear as to how effective this medication is in reducing the patient's pain. Because patients can develop hyperalagia with the continued use of Opioids and with the documentation not providing sufficient information that the medication has been effective in reducing the patient's pain, the continuation of its cannot be supported. As such, the requested service is not deemed medically appropriate and is non-certified.