

Case Number:	CM13-0061927		
Date Assigned:	12/30/2013	Date of Injury:	05/12/2009
Decision Date:	04/04/2014	UR Denial Date:	11/26/2013
Priority:	Standard	Application Received:	12/05/2013

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 60-year-old female who reported an injury on 05/12/2009 due to cumulative trauma while performing normal job duties that reportedly caused injury to multiple body parts. The patient's chronic pain was managed with multiple medications, to include Norco, Motrin, Xanax, Ambien and Soma. The patient's most recent clinical documentation noted that the patient had significant pain complaints of the bilateral wrists with decreased left-sided grip strength and decreased sensation to light touch and pinprick over the radioulnar side of the right thumb, right index finger and right long finger. The patient's diagnoses included status post left DeQuervain's and status post carpal tunnel release. The patient's treatment plan included an EMG/NCV and the continuation of medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective request for Alprazolam 1 mg: Upheld

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

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

Decision rationale: The retrospective request for alprazolam 1 mg (11/01/2013) is not medically necessary or appropriate. The clinical documentation submitted for review does indicate that the patient has been on this medication since at least 09/2012. The California Medical Treatment Utilization Schedule does not recommend the extended use of benzodiazepines as there is a high risk of physiological and psychological dependence. As the patient has been on this medication for an extended duration, the continued use would not be supported. As such, the retrospective request for alprazolam 1 mg (11/01/2013) is not medically necessary or appropriate.

Retrospective request for Carisoprodol 350mg:

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol (Soma).

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

Decision rationale: The retrospective request for carisoprodol 350 mg on 11/01/2013 is not medically necessary or appropriate. The clinical documentation supports that the patient has been on this medication since at least 09/2012. The California Medical Treatment Utilization Schedule does not recommend the extended use of this medication beyond 2 to 3 weeks for acute exacerbations of a patient's chronic pain. The clinical documentation submitted for review did provide an incomplete chart note for 10/30/2013. Therefore, there was no way to determine if the patient had an acute exacerbation of chronic pain. As the clinical documentation indicates that the patient has been on this medication for an extended duration, and there is no documentation that the patient has had an acute exacerbation of pain that would benefit from the continued use of this medication; the retrospective request for carisoprodol 350 mg on 11/01/2013 is not medically necessary or appropriate.

Retrospective request for Terocin Patch: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

Decision rationale: The retrospective request for a Terocin patch on 11/01/2013 is not medically necessary or appropriate. The clinical documentation submitted for review does indicate that the patient was prescribed a trial of gabapentin in 09/2013. However, the clinical documentation included an incomplete char note from 10/30/2013; therefore, the trial of that oral medication cannot be established. The requested Terocin patch is a compounded medication that contains menthol, methyl salicylate and capsaicin. The California Medical Treatment Utilization Schedule does not recommend the use of capsaicin unless the patient has failed to respond to other first-line treatments, such as antidepressants and anticonvulsants. As the patient recently underwent a trial of oral anticonvulsants, and the results were not provided; the appropriateness of this

medication for this patient cannot be determined. As such, the retrospective request for a Terocin patch on 11/01/2013 is not medically necessary or appropriate.