

Case Number:	CM14-0008308		
Date Assigned:	02/07/2014	Date of Injury:	09/08/2003
Decision Date:	06/25/2014	UR Denial Date:	01/13/2014
Priority:	Standard	Application Received:	01/17/2014

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 a 60-year-old female who has submitted a claim for chronic low back pain, status post lumbar fusion, and lumbar radiculopathy associated with an industrial injury date of September 8, 2003. Medical records from 2013 were reviewed. The patient complained of chronic lower back pain graded 6-7/10 with radiation into the right leg down to the bottom of the right foot. Pain was aggravated by prolonged sitting. Physical examination showed moderate lumbar paraspinal muscle tenderness and spasm, severely limited lumbar flexion, and patchy areas of diminished pinprick sensation in the right lower leg. Treatment to date has included lumbar brace, NSAIDs, muscle relaxants, topical analgesics, anticonvulsants, aquatic therapy, physical therapy, and surgery.

IMR ISSUES, DECISIONS AND RATIONALES

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

SOMA 350 MG, QUANTITY 60: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, CARISOPRODOL (SOMA), 65

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.24.2 Page(s): 29 and 65.

Decision rationale: According to pages 29 & 65 of the CA MTUS Chronic Pain Medical Treatment Guidelines, carisoprodol (Soma) is not recommended and is not indicated for long-term use. Guidelines state that its use is not recommended for longer than a 2 to 3 week period. Carisoprodol is metabolized to meprobamate, an anxiolytic that is a schedule IV controlled substance. In addition, abuse has been noted for sedative and relaxant effects. In this case, the patient has been using Soma since April 2013. Progress notes reported that Soma helps decrease muscle spasms in this patient, however, the use of this medication is way beyond the recommended period. Therefore, the request for Soma 350MG, #60 is not medically necessary.

VOLTAREN GEL 1%, QUANTITY 5: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, TOPICAL ANALGESICS, 111-113

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.24.2 Page(s): 112.

Decision rationale: Page 112 of the CA MTUS Chronic Pain Medical Treatment Guidelines states that Voltaren Gel is indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist); and has not been evaluated for treatment of the spine, hip or shoulder. In this case, the patient has been using Voltaren gel since April 2013 for additional pain relief. There were no reports of failure or intolerance to oral medications in this case. The patient noted improvement of symptoms when using this topical medication as needed for the lower back. However, the use of this topical medication for the lower back has not been evaluated and there were no subjective and objective findings in the medical records that would suggest a diagnosis of osteoarthritis in this patient. Therefore, the request for Voltaren Gel 1%, #5 is not medically necessary.