

Case Number:	CM14-0010706		
Date Assigned:	02/21/2014	Date of Injury:	11/02/2008
Decision Date:	08/05/2014	UR Denial Date:	01/03/2014
Priority:	Standard	Application Received:	01/27/2014

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 Internal Medicine, 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:

This 52-year-old had a date of injury on November 2, 2008. The mechanism of injury was she began to develop the gradual onset of lower back pain attributed to repetitive bending, stooping, pulling, pushing, lifting, and carrying. On a progress note dated October 8, 2013, the progress notes show that the patient fell, hurt her knee and was taken to Loma Linda. Examination of the lumbar spine reveals decreased range of motion with pain in all ranges. Flexion is at the hip with severe pain. Diagnostic impression shows chronic pain syndrome secondary to lumbosacral spondylolisthesis, anxiety and depression. Treatment to date: medication management, behavioral modification, and surgery. A UR decision dated January 3, 2014 denied the request for Carisoprodol 350mg #90 and hydrocodone 10/660mg #90, reducing it to a quantity of #45, stating that there is no documentation of a maintained increase or decrease in pain with the use of his medication. Therefore, its continued use would not be indicated; however, a modified number of # 45 would be indicated for the possibility of a weaning process. They also denied looperamide 2mg#30 stating that there was no evidence of diarrhea provided. Lidoderm 5% patch #60 was denied, stating that this medication is indicated for post-herpetic neuralgia, which the claimant is not noted to have. Furthermore, topical medications as a whole have not been proven efficacious.

IMR ISSUES, DECISIONS AND RATIONALES

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

Carisoprodol 350mg, ninety count: Upheld

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

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

Decision rationale: The Chronic Pain Medical Treatment Guidelines states that Soma is not indicated for long-term use. Carisoprodol is a commonly prescribed, centrally-acting skeletal muscle relaxant and is now scheduled in several states. It has been suggested that the main effect is due to generalized sedation and treatment of anxiety. Abuse has been noted for sedative and relaxant effects. Carisoprodol is metabolized to meprobamate, an anxiolytic that is a schedule IV controlled substance. Soma has been known to augment or alter the effects of other medications, including opiates and benzodiazepines. This patient is noted to be on hydrocodone, and the combination of opiates and Soma can increase the sedation and side-effects. Therefore, the request for Carisoprodol 350mg, ninety count, is not medically necessary or appropriate.

Hydrocodone 10/660mg, ninety count: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines HYDROCODONE/ACETAMINOPHEN Page(s): 91, 78.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78-81.

Decision rationale: The Chronic Pain Medical Treatment Guidelines do not support ongoing opioid treatment unless prescriptions are from a single practitioner and are taken as directed; are prescribed at the lowest possible dose; and unless there is ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The patient has been shown to be on hydrocodone 10/660 since at least March 7, 2013, with no documented functional improvement or improved activities of daily living. Furthermore, there was no evidence of CURES monitoring or pain contract. The UR decision modified the request from #90 to #45 to initiate tapering. Therefore, the request for hydrocodone 10/660, ninety count, is not medically necessary or appropriate.

Loperamide 2mg, thirty count: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: <http://www.drugs.com/imodium.html>.

Decision rationale: CA MTUS does not address this issue. The FDA states that Imodium (loperamide) is used to treat diarrhea. Imodium is also used to reduce the amount of stool in people who have an ileostomy (re-routing of the bowel through a surgical opening in the

stomach). In the records reviewed, there was no evidence that the patient had diarrhea or had an ileostomy. There was no rationale provided as to why the patient needs Imodium. Therefore, the request for loperamide 2mg, thirty count, is not medically necessary or appropriate.

Lidocaine 5% patch, sixty count: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines LIDODERM (LIDOCAINE PATCH) Page(s): 56-57.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 56-57. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter.

Decision rationale: The Chronic Pain Medical Treatment Guidelines states that topical lidocaine may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). This is not a first-line treatment and is only FDA approved for post-herpetic neuralgia. ODG states that Lidoderm is not generally recommended for treatment of osteoarthritis or treatment of myofascial pain/trigger points. However, the guidelines state that for continued use of Lidoderm patches, the area for treatment should be designated as well as number of planned patches and duration for use (number of hours per day). There should be documentation of a successful trial of Lidoderm patches, as well as a discussion of functional improvement, including the ability to decrease the patient's oral pain medications. The documentation provided does not provide this information. Furthermore, in the records reviewed, there is no documentation that the patient has failed 1st line therapy such as Gabapentin or Lyrica. Therefore, the request for Lidoderm 5% patches, sixty count, is not medically necessary or appropriate.