

Case Number:	CM14-0011546		
Date Assigned:	02/21/2014	Date of Injury:	06/04/2001
Decision Date:	07/24/2014	UR Denial Date:	01/17/2014
Priority:	Standard	Application Received:	01/29/2014

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 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 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 39-year-old male with a 6/4/01 date of injury. On 12/13/13 the patient complained of ongoing pain in the neck, shoulder, back, and bilateral lower extremities. The patient has attended postoperative physical therapy for the left shoulder and has been authorized for a spinal cord stimulator. There was cervical spine tenderness, but no upper extremity motor deficits, neurological examination was unremarkable. The patient had some tenderness at the right hip with restricted and painful range of motion. Strength and lower extremities was full except for left ankle dorsiflexion tibialis anterior and great toe extension EHL was 3/5. Left plantar flexion gastrocnemius was 4/5. The patient had left foot drop. Medication refill was requested. It was noted that medications are effective in reducing pain and providing functional gains and activities of daily living, exercises, and restorative sleep. Current medications include Norco 10/325 mg, 1-2 tablets q6 hours; Soma 350 mg, q8 hrs; Mobic 15mg, OD; and alprazolam 0.5 mg, 1-2 tablets a day. The patient is scheduled for spinal cord stimulator after completing physical therapy. A 12/13/13 UDS was positive for Xanax, hydrocodone, meprobamate, and Hydromorphone. The treating provider has requested Mobic 15mg #30, Aprazolam 0.5mg 1-2 qd # 45, and Soma 350mg tid # 90.

IMR ISSUES, DECISIONS AND RATIONALES

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

Mobic 15 mg 1 Tab PO Once Daily #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009), NSAIDs Page(s): 46. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter (NSAIDs).

Decision rationale: The ODG indicates that NSAIDs are recommended for acute pain, acute LBP, short-term pain relief in chronic LBP, and short-term improvement of function in chronic LBP. There is no evidence of long-term effectiveness for pain or function. There is conflicting evidence that NSAIDs are more effective than acetaminophen for acute LBP. There is inconsistent evidence for the use of these medications to treat long-term neuropathic pain, but they may be useful to treat breakthrough pain in this condition. Besides the well-documented side effects of NSAIDs, there are other less well-known effects of NSAIDs, and the use of NSAIDs has been shown to possibly delay and hamper healing in all the soft tissues, including muscles, ligaments, tendons, and cartilage. Medical necessity for this medication is not established. Meloxicam is a nonsteroidal anti-inflammatory drug (NSAID) for the relief of the signs and symptoms of osteoarthritis, however there is no indication of a diagnosis of osteoarthritis in this young injured worker. There is no clear description of reduction in VAS (visual analog scale) score attributed to this medication, or specific functional improvement attributed to its use. Due to associated gastric and other side effects, chronic use of NSAIDs is generally not recommended. The medical necessity for the requested item has not been established. The requested item is not medically necessary.

ALPRAZOLAM 0.5 MG 1 TAB 1-2 A DAY PO #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 (ODG)--Treatment in Workers Comp (TWC), Online Edition, Chapter: Pain, Alprazolam (Xanax).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CA MTUS 2009: 9792.24.2. Benzodiazepines Page(s): 24.

Decision rationale: Chronic Pain Medical Treatment Guidelines indicate that benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. Their range of action includes sedative/hypnotic, anxiolytic, anticonvulsant, and muscle relaxant. Chronic benzodiazepines are the treatment of choice in very few conditions. Tolerance to hypnotic effects develops rapidly. Tolerance to anxiolytic effects occurs within months and long-term use may actually increase anxiety. A more appropriate treatment for anxiety disorder is an antidepressant. Tolerance to anticonvulsant and muscle relaxant effects occurs within weeks. Medical necessity for the requested benzodiazepine is not established. The California MTUS Chronic Pain Medical Treatment Guidelines indicate that benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. The injured worker has a 2001 date of injury, and duration of use has not been adequately described. Due to risk of dependence and lack of long-term efficacy, the

request is not substantiated. There is no diagnosis of anxiety listed in the records. No additional medical records were provided following the prior adverse determination. The medical necessity for the requested item has not been established. The requested item is not medically necessary.

SOMA 350 MG 1 TAB Q8 HOURS #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CA MTUS 2009: 9792.24.2. Carisoprodol (Soma).

Decision rationale: Medical necessity for the requested Soma is not established, as guideline criteria are not met. The injured worker has a 2001 date of injury, yet little has been discussed regarding duration of medication use. The injured worker is prescribed Soma and Norco, according to a 12/13/13 progress note. Guidelines indicate that Soma and hydrocodone can lead to an effect that some abusers claim is similar to heroin. The California MTUS states that Soma is not recommended. Carisoprodol is metabolized to meprobamate an anxiolytic that is a schedule IV controlled substance. As guidelines do not support this medication for chronic use, the request is not substantiated. The medical necessity for the requested item has not been established. The requested item is not medically necessary.