

Case Number:	CM14-0018394		
Date Assigned:	04/18/2014	Date of Injury:	04/13/2000
Decision Date:	08/25/2014	UR Denial Date:	01/31/2014
Priority:	Standard	Application Received:	02/13/2014

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 and Rehabilitation and is licensed to practice in Physical Medicine and Rehabilitation. 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 injured worker is a 51-year-old female who reported an injury on 04/13/2000 due to an unknown mechanism. The injured worker's diagnoses were post laminectomy syndrome through the lumbar region; thoracic lumbosacral radiculitis unspecified; lumbago; unspecified myalgia and myositis; and unspecified neuralgia, neuritis, and radiculitis. The injured worker's prior diagnostics were MRI of the spine dated 03/20/2013, 04/25/2011 and 06/05/2005 as well as x-rays of the lumbar spine performed on 01/10/2007. The injured worker complained of chronic low back pain, bilateral leg and bilateral hip pain, and left foot drop pain. The injured worker rated pain at 7/10 without and functional level at 6/10 with medication. In the physical examination dated 01/21/2014, it was noted that the injured worker continued to have low back pain that radiated into both legs. Left leg pain was greater than the right with symptoms to the foot and the toe. There was tenderness to the lumbar paraspinal muscle and spasming at the lower lumbar and sacral spine. The injured worker had been in severe pain due to not having her full complements of medications. The injured worker's documentation notates on the most current clinical visit as well as prior clinical visits of being on Soma. It is not made clear within the documentation. On the clinical documentation dated 10/22/2013, there was notation of this medication being part of the injured worker's medication regimen. The provider's treatment plan was to continue medical management. The rationale for the request was not documented. The request for authorization form was not provided with documentation submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

RETROSPECTIVE USAGE OF SOMA #90: Upheld

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

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

Decision rationale: The request for retrospective usage of Soma, # 90 is not medically necessary. The requested medication was also prescribed centrally as an acting skeletal muscle relaxant. According to California MTUS Guidelines recommends a non-sedating muscle relaxant with caution as a second line option for short term treatment of acute exacerbation in patients with chronic low back pain. Although the injured worker continued to complain of pain, cited guidelines do not support the use of Soma as a long term treatment. On the clinical documentation dated 10/22/2013, there was notation of this medication being part of the injured worker's medication regimen which exceeds the recommended time frame. There was lack of documentation as to the efficacy and safety that warrant continuation of this medication. In addition, there is a lack of documentation of frequency on the proposed request. As such, the request for retrospective usage of soma #90 is not medically necessary.

RETROSPECTIVE USAGE OF VALIUM 10MG, #30: Upheld

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

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

Decision rationale: The retrospective usage of Valium 10 mg, #30 is not medically necessary. The California MTUS does not support the use of benzodiazepines for long term use because long term efficacy is unproven and there is a risk of dependence. Chronic benzodiazepines are the treatment of choice in very few conditions. Tolerance to hypnotic effect develops rapidly. There was no documentation to support the efficacy of this medication for continued use and Guidelines do not recommend long term use. On the clinical documentation dated 10/22/2013 there was notation of this medication being part of the injured worker's medication regimen which exceeds the recommended time frame. In addition, the proposed request does not mention the frequency of the medication requested. As such, the request for retrospective usage of Valium 10 mg #30 is not medically necessary.

RETROSPECTIVE USAGE OF ABSTRAL 600UGM #96: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines On-going management of opioids Page(s): 78.

Decision rationale: The request for retrospective usage of Abstral 600 ugm #96 is not medically necessary. According to the California MTUS Guidelines, the ongoing management of a patient taking opioid medications should include routine office visits and detailed documentation of the extent of pain, functional status in regards to activities of daily living, appropriate medication use, and/or aberrant drug taking behaviors and adverse side effects. The pain assessment should include current pain, the least reported pain over the period since the last assessment, the average pain, and the intensity of pain after taking the opioid, how long it takes for pain relief, and how long relief lasts. The injured worker complained of low back pain with bilateral leg and bilateral hip pain. The injured worker rated the pain at 7/10 and a functional level at 610. The injured worker was noted to have some increase in ability to perform activities of daily living with the use of medication. There was no documentation of any adverse effects with the use of opioids. Clinical documentation submitted for review there was a notation that the medication was not beneficial and the injured worker did not like it. In the absence of documentation of a comprehensive pain assessment, and documentation of how long the pain relief lasts, the Guidelines do not support continuation. In addition, the request lacked mention of frequency for the proposed medication. Given the above, the request for retrospective usage of Abstral 600UGM #96 is not medically necessary.