

Case Number:	CM14-0122159		
Date Assigned:	08/08/2014	Date of Injury:	10/10/2007
Decision Date:	10/01/2014	UR Denial Date:	07/24/2014
Priority:	Standard	Application Received:	08/01/2014

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 Occupational 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:

According to the records made available for review, this is a 41-year-old female with a 10/10/07 date of injury, status post spinal fusion (undated), status post carpal tunnel release (undated), and status post gastric bypass (undated). A request for authorization was submitted for 90 Soma 350mg with 1 refill, 5 Sprix 15.75mg Nasal spray with 1 refill, 90 Acetaminophen 500mg with 1 refill, 120 Gabapentin 800mg with 1 refill, and Ambien 10mg #30. At the time of request (7/15/14), there is documentation of subjective complaints including pain in the neck and lower back with radiation into the right leg, pain level 9/10, muscle spasms, numbness, tingling, and weakness. Also documented were objective findings, including spasm and tenderness noted in cervical and lumbar spine; motor examination grossly normal for bilateral upper extremities; spinous process tenderness noted on L4-5; lumbar facet loading positive on both sides; straight leg raising test positive; ankle and patellar jerk 0/4 on both sides; and decreased sensation along right calf. Current diagnoses are listed as cervical facet syndrome, depression with anxiety, disc disorder lumbar, lumbar and lumbosacral fusion of the anterior column, posterior technique, myalgia and myositis not otherwise specified, and radiculopathy. Treatment to date has consisted of physical therapy, a home exercise program, and medications, including ongoing treatment with Soma, Sprix, Acetaminophen, and Gabapentin since at least 1/21/14 and Ambien since at least 6/17/14; with medications, the claimant is noted to have experienced reduction of pain, improved function, and increased activities of daily living. Regarding 90 Soma 350mg with 1 refill, there is no documentation of acute muscle spasms and the intention to treat over a short course. Regarding 5 Sprix 15.75mg Nasal spray with 1 refill, there is no documentation of pain requiring analgesia at the opioid level, the intention to treat over a short course, and failure of first-line medication to manage chronic pain. Regarding Ambien 10mg #30, there is no documentation of insomnia and the intention to treat over a short course.

IMR ISSUES, DECISIONS AND RATIONALES

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

90 Soma 350mg with 1 refill: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol (Soma) Page(s): 29. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Muscle relaxants (for pain)

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies that Carisoprodol (Soma) is not recommended and that this medication is not indicated for long term use. The MTUS Definitions section identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement, such as a reduction in work restrictions, an increase in activity tolerance, and/or a reduction in the use of medications or medical services. ODG identifies that muscle relaxants are recommended as a second-line option for short-term (less than two weeks) treatment of acute low back pain and for short-term treatment of acute exacerbations in patients with chronic low back pain. Within the medical information available for review, there is documentation of diagnoses of cervical facet syndrome, depression with anxiety, disc disorder lumbar, lumbar and lumbosacral fusion of the anterior column, posterior technique, myalgia and myositis not otherwise specified, and radiculopathy. In addition, there is documentation of muscle spasms. Furthermore, given documentation of ongoing treatment with Soma and reduction of pain and improved function and increased activities of daily living with medications, there is documentation of functional benefit and improvement as an increase in activity tolerance as a result of Soma use to date. However, there is no documentation of acute muscle spasms. In addition, given documentation of records reflecting prescriptions for Carisoprodol/Soma since at least 1/21/14, there is no indication of the intention to treat over a short course (less than two weeks). Therefore, based on guidelines and a review of the evidence, the request for 90 Soma 350mg with 1 refill is not medically necessary.

5 Sprix 15.75mg Nasal spray with 1 refill: 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), Pain (Chronic)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Ketorolac (Toradol)

Decision rationale: The California MTUS does not address this issue, aside from stating in the Definitions section that any treatment intervention should not be continued in the absence of functional benefit or improvement, such as a reduction in work restrictions, an increase in

activity tolerance, and/or a reduction in the use of medications or medical services. ODG identifies documentation of moderate to moderately severe pain requiring analgesia at the opioid level as criteria necessary to support the medical necessity of Sprix nasal spray for a short duration (not to exceed 5 days). In addition, ODG does not recommended Sprix as a first-line medication for chronic pain. Within the medical information available for review, there is documentation of diagnoses of cervical facet syndrome, depression with anxiety, disc disorder lumbar, lumbar and lumbosacral fusion of the anterior column, posterior technique, myalgia and myositis not otherwise specified, and radiculopathy. In addition, there is documentation of moderate to moderately severe pain. Furthermore, given documentation of ongoing treatment with Sprix and reduction of pain and improved function and increased activities of daily living with medications, there is documentation of functional benefit and improvement (increase in activity tolerance) as a result of Sprix use to date. However, there is no documentation of pain requiring analgesia at the opioid level. In addition, given documentation of ongoing treatment with Sprix since at least 1/21/14, there is no documentation of the intention to treat over a short course (not to exceed 5 days). Furthermore, there is no documentation of a failure of first-line medication for chronic pain. Therefore, based on guidelines and a review of the evidence, the request for 5 Sprix 15.75mg Nasal spray with 1 refill is not medically necessary.

90 Acetaminophen 500mg with 1 refill: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Acetaminophen (APAP).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Acetaminophen (APAP) Page(s): 11-12.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of chronic pain, acute exacerbations of chronic pain, mild to moderate osteoarthritis pain, and chronic low back pain as criteria necessary to support the medical necessity of acetaminophen. The Definitions section of the MTUS identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement such as a reduction in work restrictions, an increase in activity tolerance, and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of cervical facet syndrome, depression with anxiety, disc disorder - lumbar, lumbar and lumbosacral fusion of the anterior column, posterior technique, myalgia and myositis not otherwise specified, and radiculopathy. In addition, there is documentation of chronic low back pain. Furthermore, given documentation of ongoing treatment with Acetaminophen and reduction of pain and improved function and increased activities of daily living with medications, there is documentation of functional benefit and improvement (increase in activity tolerance) as a result of Acetaminophen use to date. Therefore, based on guidelines and a review of the evidence, the request for 90 Acetaminophen 500mg with 1 refill is medically necessary.

120 Gabapentin 800mg with 1 refill: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin (Neurontin) Page(s): 18-19.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of neuropathic pain as a criterion necessary to support the medical necessity of Neurontin (Gabapentin). The MTUS Definitions section identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement, such as a reduction in work restrictions, an increase in activity tolerance, and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of cervical facet syndrome, depression with anxiety, disc disorder lumbar, lumbar and lumbosacral fusion of the anterior column, posterior technique, myalgia and myositis not otherwise specified, and radiculopathy. In addition, there is documentation of neuropathic pain. Furthermore, given documentation of ongoing treatment with Gabapentin and the reduction of pain and improved function and increased activities of daily living with medications, there is documentation of functional benefit and improvement as a result of Gabapentin use to date. Therefore, based on guidelines and a review of the evidence, the request for 120 Gabapentin 800mg with 1 refill is medically necessary.

Ambien 10mg #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines- Zolpidem (Ambien)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter, Zolpidem

Decision rationale: The California MTUS does not address this issue, aside from stating in the Definitions section that any treatment intervention should not be continued in the absence of functional benefit or improvement, such as a reduction in work restrictions, an increase in activity tolerance, and/or a reduction in the use of medications or medical services. ODG identifies Ambien (Zolpidem) as a short-acting, non-benzodiazepine hypnotic, which is approved for the short-term (usually two to six weeks) treatment of insomnia. Within the medical information available for review, there is documentation of diagnoses of cervical facet syndrome, depression with anxiety, disc disorder lumbar, lumbar and lumbosacral fusion of the anterior column, posterior technique, myalgia and myositis not otherwise specified, and radiculopathy. However, there is no documentation of insomnia. In addition, given documentation of records reflecting prescriptions for Zolpidem since at least 6/17/14 and a request for Ambien 10mg #30, there is no indication of the intention to treat over a short course only (less than two to six weeks). Therefore, based on guidelines and a review of the evidence, the request for Ambien 10mg #30 is not medically necessary.