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| Case Number: | CM14-0122916 | | |
| Date Assigned: | 08/08/2014 | Date of Injury: | 01/12/2006 |
| Decision Date: | 09/23/2014 | UR Denial Date: | 07/17/2014 |
| Priority: | Standard | Application Received: | 08/04/2014 |

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, Pain 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:

The injured worker is a 72 year old female who reported an injury on 01/12/2006; the mechanism of injury was not provided. Current diagnoses include chronic myofascial pain syndrome of the cervical and thoracic spine, right shoulder sprain, and depression. Past treatments included a cane and medications. Diagnostic studies were not included. Surgical history included cervical decompression and fusion at C4-5, C5-6 and C6-7 on 01/15/2008, and right rotator cuff surgery, date unknown. The clinical note dated 06/19/2014 indicated the injured worker complained of constant neck and upper back pain rating it 7-8/10 without medications. The injured worker reported being able to perform activities of daily living well and greater than 50% pain relief when taking medications. She went on to state that her current pain and discomfort was moderately affecting her general activity, quality of sleep, and enjoyment of life. She rated her depression 4/10. Physical exam of the spine indicated restricted range of motion and multiple myofascial trigger points and muscle spasms. Current medications included Hydrocodone 7.5/325 mg, Naproxen 550 mg, Topiramate 50 mg, and Cymbalta 60 mg. The treatment plan included duloxetine and darisoprodol. The rationale for duloxetine was for the relief treatment of depression. The rationale for carisoprodol was not provided. The request for authorization form for duloxetine was submitted on 06/19/2014. The request for authorization form for carisoprodol was not provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

Duloxetine Cap 60 mg #30 with 4 refills: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Guidelines, 2nd Edition.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Duloxetine (Cymbalta) Page(s): 43-44.

Decision rationale: The injured worker had a diagnosis of depression. California MTUS Guidelines indicate that duloxetine is FDA approved for the treatment of depression. Clinical notes indicated the injured worker had been taking the medication since at least 01/27/2014, and rated her depression 4/10. There is a lack of documentation indicating the injured worker has significant objective functional improvement with the medication. The request for duloxetine does not include indicators for quantity and frequency. Furthermore, four refills would not allow for the periodic reassessment of efficacy. Therefore, the request for duloxetine with 4 refills is found to be not medically necessary.

Carisoprodol tab 350mg #60 with 4 refills: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Guidelines, 2nd Edition.

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

Decision rationale: The injured worker complained of constant neck and upper back pain. California MTUS Guidelines indicate that carisoprodol (Soma) is not recommended and not indicated for long-term use. There is no clinical documentation to support the request outside of what the guidelines indicate. The request does not indicate frequency for taking the medication. The request does include four refills which would not allow for periodic reassessment of efficacy. Therefore, the request for carisoprodol 350 mg with four refills is found to be not medically necessary.