

Case Number:	CM14-0136044		
Date Assigned:	09/03/2014	Date of Injury:	03/24/2011
Decision Date:	09/30/2014	UR Denial Date:	08/14/2014
Priority:	Standard	Application Received:	08/25/2014

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 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 patient is a 53-year-old male who has submitted a claim for acquired spondylolisthesis associated with an industrial injury date of March 24, 2011. Medical records from 2014 were reviewed. The patient complained of constant low back pain radiating to the buttocks, thighs and ankles accompanied by numbness and tingling sensation. Pain was rated 9-10/10. The patient also complains of difficulty falling asleep. Physical examination of the lumbar spine showed limitation of motion; lumbar paraspinal tenderness, muscle guarding and spasm bilaterally; exquisite tenderness at the SI joint bilaterally; positive Valsalva, Kemp's, iliac compression, and facet sign; and positive straight leg raise bilaterally. The diagnoses were lumbar disc bulging at L3-4, L4-5, and L5-S1; moderate L5 radiculopathy of bilateral lower extremities; and insomnia. Treatment to date has included TENS, Vicodin, Ultram, Soma, Gabacyclotram, Flurbi, and Prilosec. Utilization review from August 14, 2014 denied the request for carisoprodol 350mg tab #120 because there was no explicit documentation of spasm relief from this medication. The request for zolpidem tartrate 10mg tab #30 with 4 refills was also denied because there are no results of sleep behavior modification attempts or documentation of failed trials of other guideline-supported treatments. The request for hydrocodone-acetaminophen 10/325mg #120 with 4 refills was modified to #120 to initiate weaning process. There was no documented symptomatic or functional improvement from its previous use.

IMR ISSUES, DECISIONS AND RATIONALES

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

Carisoprodol 350mg tab #120 with 4 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol (Soma), Carisoprodol (Soma, Soprodal 350TM, Vanadom, generic available) Page(s): 29,65.

Decision rationale: As stated on pages 29 and 65 of CA MTUS Chronic Pain Medical Treatment Guidelines, carisoprodol is not indicated for long-term use. It is a commonly prescribed, centrally-acting skeletal muscle relaxant and is now scheduled in several states. Abuse has been noted for sedative and relaxant effects. Carisoprodol is metabolized to meprobamate, an anxiolytic that is a schedule IV controlled substance. In this case, the exact initial date of Soma intake was not mentioned. It is unclear whether the patient has been on chronic use of this medication. Moreover, the requested number of medication implies long-term use. The guideline does not recommend this medication as well as its long-term use. The medical necessity has not been established. There was no compelling rationale for continued use of this medication. Therefore, Carisoprodol 350mg tab #120 with 4 refills is not medically necessary.

Hydrocodone-Acetaminophen 10-325mg #120 with 4 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use Page(s): 78-80.

Decision rationale: As stated on pages 78-80 of CA MTUS Chronic Pain Medical Treatment Guidelines, on-going management of opioid use should include ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Use of opioids for chronic low back pain is only recommended for short-term pain relief. The guideline also states that opioid intake may be continued when the patient has returned to work and has improved functioning and pain. In this case, the patient has been taking hydrocodone (Vicodin) for pain. However, there was no objective evidence of continued analgesia and functional improvement directly attributed with its use. Likewise, current work status of the patient was not documented and no urine drug screens were done. The guideline requires documentation of functional and pain improvement, monitoring for aberrant drug-taking behavior, and return to work prior to continued opioid use. Moreover, the exact initial date of use was not mentioned. It is unclear whether there is chronic use of this medication. The guideline does not recommend long-term opioid use for chronic low back pain. The guideline criteria were not met. Therefore, the request for Hydrocodone-Acetaminophen 10-325mg #120 with 4 refills is not medically necessary.

Zolpidem Tartrate 10mg #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 Official Disability Guidelines.

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

Decision rationale: The CA MTUS does not specifically address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers Compensation, the Official Disability Guidelines (ODG), was used instead. ODG states Ambien (zolpidem) is a prescription short acting nonbenzodiazepine hypnotic, which is approved for the short-term (usually two to six weeks) treatment of insomnia. Proper sleep hygiene is critical to the individual with chronic pain and often is hard to obtain. In this case, patient has insomnia for which zolpidem was prescribed. However, the patient's sleep pattern was not discussed. There was also no evidence of failure of sleep hygiene techniques to manage sleep problem. Moreover, the requested number of medication implies long-term use, which is not supported by the guideline. The medical necessity has not been established. There was no compelling rationale concerning the need for variance from the guideline. Therefore, the request for Zolpidem Tartrate 10mg #30 with 4 refills is not medically necessary.