

Case Number:	CM14-0153933		
Date Assigned:	09/23/2014	Date of Injury:	03/01/2006
Decision Date:	11/24/2014	UR Denial Date:	08/28/2014
Priority:	Standard	Application Received:	09/22/2014

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 Family 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 records provided for my review contain no progress notes from any of the patient's providers. All of the information contained in this report was gleaned from UR reports, from a chiropractic QME report dated 4/19/14, and from operative reports for cervical epidural steroid injections. This is a 60-year old building and grounds worker reported injuries to her left wrist and elbow and right ankle sustained while throwing trash into a compactor on 3/1/06. Diagnoses of left carpal tunnel syndrome, cervical radiculopathy, depression and anxiety have apparently been added with time. The patient's past medical history is notable for alcoholism, asthma, surgery for cancer, and two previous Workers' Compensation claims, including one for stress. She continues to smoke and to drink socially according to the 4/9/14 QME report. Treatment has included splints, medications, chiropractic manipulation, physical therapy, acupuncture, a steroid injection of the left wrist, a surgical left carpal tunnel release performed 4/5/07, and two cervical epidural steroid injections. The patient has not worked since approximately 2007, although she has apparently been advised to return to work with restrictions. The patient has been taking oxycodone, Soma and lorazepam since at least 4/13/09. The records contain UR reports dated 7/18/14 in which oxycodone and Soma were deemed medically unnecessary. A follow up peer review report from the same reviewing physician dated 7/19/14 states that the reviewer had talked to the primary treater, and that the treater had agreed to decrease the patient's oxycodone dosage by 10%. Apparently a month's supply of oxycodone was authorized to allow for weaning. On 8/21/14 the treating provider submitted a request for oxycodone 30 mg #120 and for Soma 350 mg #90, which represented no decrease at all from previous requests. The requests were not certified in UR on 8/28/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Roxicodone 30mg #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain Criteria for use of Opioids Opioids for neuropathic pain, Opioid.

Decision rationale: Roxicodone is brand-name oxycodone, which is an opioid analgesic. Per the first citation above, medications should be started individually while other treatments are held constant, with careful assessment of function. There should be functional improvement with each medication in order to continue it. The other citations state that opioids should not be started without an evaluation of the patient's current status in terms of pain control and function. An attempt should be made to determine if the patient's pain is nociceptive or neuropathic. Red flags indicating that opioid use may not be helpful should be identified, as should risk factors for abuse. Specific goals should be set, and continued use of opioids should be contingent on meeting these goals. Opioids should be discontinued if there is no improvement in function or if there is a decrease in function. Opioids are not recommended as first-line therapy for neuropathic pain. Opioid dosing should not exceed 120 oral mg equivalents per day. The clinical findings in this case do not support the continued use of Roxicodone. There is no evidence of any evaluation to determine if the patient's pain is nociceptive or neuropathic. Pain from carpal tunnel syndrome and from cervical radiculopathy is neuropathic. Since this patient is being treated for both of these conditions, her pain is probably neuropathic and is less likely to respond to opioids. No assessment for risk factors for abuse appears to have occurred. This patient has obvious risk factors, including continuing to drink despite a history of alcoholism, and continuing to smoke despite diagnoses of asthma, high blood pressure and hyperlipidemia. She probably should not have been prescribed any potentially addictive medications in the first place. Although it is not explicitly stated, the patient's current (and long-term) dose of Roxicodone appears to be 30 mg four times per day, which would mean that she is taking 180 mg oral morphine equivalents per day. This is well above the recommended maximum dosage. This amount of Roxicodone may be causing side effects such as dizziness and drowsiness, which contribute to the patient's failure to make any functional recovery. There is no evidence that any functional goals were set or are being monitored as a condition of continued Roxicodone use. The patient remains off work, which would imply that no substantial functional recovery has occurred. Based on the MTUS citations above, Due to the lack of appropriate documentation of the patient's status prior to beginning it, on the likelihood that its dosage is in excess of that recommended, on the failure to set and monitor functional goals, and on the failure to discontinue it when it became clear that it has not produced significant functional recovery, therefore the request for Roxicodone 30 mg #120 is not medically necessary.

Soma 350mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain Carisoprodol Page(s): 60 29.

Decision rationale: Soma is brand-name carisoprodol, which is a centrally acting skeletal muscle relaxant. According to the first guideline cited above, medications should be started individually while other treatments are held constant, with careful assessment of function. There should be functional improvement with each medication in order to continue it. The second guideline states that carisoprodol is not recommended, and is not indicated for long-term use. Its primary metabolite, meprobamate, is a controlled substance. Carisoprodol has substantial abuse potential. It also may augment the effects of other drugs including benzodiazepines and hydrocodone, resulting in increased sedation. Some abusers claim that the combination of carisoprodol and hydrocodone produces effects that are similar to those of heroin. The records in this case reveal that this patient has been on Soma for a very long time. This patient has not worked since 2007, and there is no documented evidence that Soma has improved her level of function in any way. Given its sedating effects, especially in combination with several of the other medications the patient is taking, it seems quite likely that Soma is contributing to this patient's low functional level. In addition, Soma's abuse potential is of concern, since this patient has risk factors for abuse. The records do not contain evidence that this concern has been addressed. The medication should not be taken long-term, because it has substantial abuse potential, and because its use has not resulted in any functional improvement in this patient and may in fact be contributing to her ongoing low level of function. Therefore the request for Soma 350 mg #90 is not medically necessary.