

Case Number:	CM14-0157296		
Date Assigned:	09/30/2014	Date of Injury:	03/25/2014
Decision Date:	10/28/2014	UR Denial Date:	09/03/2014
Priority:	Standard	Application Received:	09/25/2014

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 Internal Medicine and is licensed to practice in New York. 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 claimant is a 42 year old male who sustained an industrial injury on 03/25/2014. The mechanism of injury was not provided for review. His diagnosis is left rotator cuff tear status post arthroscopic surgery with repair. On exam he has left shoulder flexion abduction at 160 degrees, extension at 40 degrees. Treatment in addition to surgery has included medications Percocet, Ambien Soma, Trazodone, Ultram, and Flexeril and physical therapy. The treating provider has requested Percocet 10/325, Ambien 10 mg, Soma 350 mg, Trazodone 50 mg, retro Oxycodone /Acetaminophen 10/325 (Date of service 8/4/14) and Carisoprodol 350 mg (Date of service 0/4/14).

IMR ISSUES, DECISIONS AND RATIONALES

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

Percocet 10/325mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 91-97.

Decision rationale: The documentation indicates the enrollee has been treated with opioid therapy with Percocet 10/325 mg. Per California MTUS Guidelines, short-acting opioids are seen

as an effective method in controlling chronic pain. They are often used for intermittent or breakthrough pain. The treatment of chronic pain with any opioid agent requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include current pain: last reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid, and the duration of pain relief. Per the medical documentation there has been no documentation of the medication's pain relief effectiveness and no clear documentation that he has responded to ongoing opioid therapy. According to the California MTUS Guidelines there has to be certain criteria followed including an ongoing review and documentation of pain relief and functional status. This does not appear to have occurred with this patient. The patient has continued pain despite the continued use of short acting opioid medications. Medical necessity for the requested item has not been established. The requested treatment is not medically necessary.

Ambien 10mg: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines - TWC Pain Procedure Summary (last updated 7/10/14)

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

Decision rationale: Ambien is a short-acting non-benzodiazepine hypnotic indicated for the short-term treatment (two to six weeks) for managing insomnia. Per ODG guidelines, long-term use is not recommended as there are associated risks of impaired function and memory with use more than opioids, as well as Ambien may be habit forming. There are no subjective findings of insomnia noted in the medical record and no documentation of any sleep disorder. Medical necessity for the requested item has not been established. The requested item is not medically necessary.

Soma 350mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines - TWC Pain Procedure Summary (last updated 7/10/14)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 41.

Decision rationale: Per the reviewed literature, Carisoprodol (Soma) is not recommended for the long-term treatment of musculoskeletal pain. The medication has its greatest effect within 2 weeks. It is suggested that the main effect of the medication is due to generalized sedation and treatment of anxiety. Soma is classified as a Schedule IV drug in several states. It can cause physical and psychological dependence as well as withdrawal symptoms with abrupt discontinuation. The documentation does not indicate there are palpable muscle spasms and there

is no documentation of functional improvement from any previous use of this medication. Per CA MTUS Guidelines muscle relaxants are not considered any more effective than nonsteroidal anti-inflammatory medications alone. Based on the currently available information, the medical necessity for chronic use of this muscle relaxant medication has not been established. The requested treatment is not medically necessary.

Trazodone 50mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

Decision rationale: Trazodone is indicated for the treatment of sleep disorders including insomnia and depression. The medication has anxiolytic and sleep-inducing effects. There is no specific reference to pain or depression as the medical indication for this medication. Medical necessity for the requested item has not been established. The requested item is not medically necessary.

Retrospective request for Oxycodone/Acetaminophen 10/325 mg (Date of service: 8/4/14): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 91-97.

Decision rationale: The documentation indicates the enrollee had been treated with opioid therapy with Percocet 10/325 mg. Per California MTUS Guidelines, short-acting opioids are seen as an effective method in controlling chronic pain. They are often used for intermittent or breakthrough pain. The treatment of chronic pain with any opioid agent requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include current pain: last reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid, and the duration of pain relief. Per the medical documentation there had been no documentation of the medication's pain relief effectiveness and no clear documentation that he had responded to ongoing opioid therapy. According to the California MTUS Guidelines there has to be certain criteria followed including an ongoing review and documentation of pain relief and functional status. This does not appear to have occurred with this patient. The patient had continued pain despite the continued use of short acting opioid medications. Medical necessity for the requested item had not been established. The requested treatment was not medically necessary.

Retrospective request for Carisoprodol 350 mg (Date of service: 8/4/14): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 41.

Decision rationale: Per the reviewed literature, Carisoprodol (Soma) is not recommended for the long-term treatment of musculoskeletal pain. The medication has its greatest effect within 2 weeks. It is suggested that the main effect of the medication is due to generalized sedation and treatment of anxiety. Soma is classified as a Schedule IV drug in several states. It can cause physical and psychological dependence as well as withdrawal symptoms with abrupt discontinuation. The documentation did not indicate there were palpable muscle spasms and there was no documentation of functional improvement from any previous use of this medication. Per CA MTUS Guidelines muscle relaxants are not considered any more effective than nonsteroidal anti-inflammatory medications alone. Based on the currently available information, the medical necessity for chronic use of this muscle relaxant medication was not established. The requested treatment was not medically necessary.