

<b>Case Number:</b>	CM14-0026118		
<b>Date Assigned:</b>	06/13/2014	<b>Date of Injury:</b>	09/05/2010
<b>Decision Date:</b>	08/13/2014	<b>UR Denial Date:</b>	02/19/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/28/2014

### 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 injured worker is a 25-year-old female who reported an injury on 09/05/2010. The mechanism of injury was not provided within the documentation. The injured worker had prior treatments of surgical intervention, physical therapy, and medication. The injured worker's diagnoses were noted to be labral hip tear, right sacroiliitis, contusion right anterior-superior iliac spine, and right greater trochanteric bursitis. The injured worker had a clinical evaluation on 10/28/2013. She had complaints of right hip pain with popping. She stated that her pain was more severe when her right hip pops. On a pain intensity scale of 1 to 10, the injured worker rated her pain at a 5 to 7. The objective findings were tenderness in the right groin and lateral aspect of the right hip. Active range of motion was impaired on the right hip with flexion, rotation, abduction, and adduction. In addition, it is noted she had weakness of hip flexors and extensors. The treatment plan was for Percocet for breakthrough pain and Norco on a regular basis for chronic pain. Routine medications of Norco, Ativan, Soma, and Percocet were provided refills and a urine drug screen will be performed at the next visit for medication compliance. The provider's rationale for the requested medications was within the documentation dated 10/28/2013. A request for authorization for medical treatment was not provided within the documentation.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**MOTRIN 800MG #90 WITH 3 REFILLS:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 67-73.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 67-68.

**Decision rationale:** The request for Motrin 800 mg #90 with 3 refills is not medically necessary. The California MTUS Chronic Pain Medical Treatment Guidelines recommend NSAIDs at the lowest dose for the shortest period in patients with moderate to severe pain. There is no evidence of long-term effectiveness for pain or function with use of NSAIDs. The treatment plan in the clinical evaluation dated 10/28/2013 does not provide an indication for Motrin. It is not indicated in the pain assessment that the injured worker takes Motrin and receives effective pain control. The requested dose of 800 mg is in excess of the Guideline recommendation for lowest dose and shortest period of treatment. In addition, the request fails to provide a frequency. Therefore, the request for Motrin 800 mg #90 with 3 refills is not medically necessary.

**SOMA 350MG #90 WITH 3 REFILLS:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines CARISOPRODOL Page(s): 65.

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

**Decision rationale:** The request for Soma 350 mg #90 with 3 refills is not medically necessary. The California MTUS Chronic Pain Medical Treatment Guidelines do not recommend Soma. This medication is not indicated for long-term use. There is little research in terms of high dose Soma and there is no standard treatment regimen for patients with known dependence. The injured worker routinely takes Soma according to the treatment plan in the clinical evaluation dated 10/28/2013. There is an inadequate pain assessment. It is unknown if Soma provides efficacy for the injured worker. The request fails to indicate a frequency. Therefore, the request for Soma 350 mg #90 with 3 refills is not medically necessary.

**ATIVAN 1MG #30 WITH 3 REFILLS:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines BENZODIAZEPINES Page(s): 24.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

**Decision rationale:** The request for Ativan 1 mg #30 with 3 refills is not medically necessary. The California MTUS Chronic Pain Medical Treatment Guidelines do not recommend benzodiazepines for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most Guidelines limit use to 4 weeks. Tolerance to hypnotic effects develops rapidly. The clinical evaluation dated 10/28/2013 indicates the injured worker routinely using

Ativan. The Guidelines do not support long-term use of benzodiazepines. There is now indication within the clinical note that Ativan provided efficacy for the injured worker. In addition, the provider's request for Ativan fails to indicate a frequency. Therefore, the request for Ativan 1 mg #30 with 3 refills is not medically necessary.