

Case Number:	CM14-0028906		
Date Assigned:	06/16/2014	Date of Injury:	07/02/2009
Decision Date:	08/20/2014	UR Denial Date:	02/27/2014
Priority:	Standard	Application Received:	03/06/2014

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 & Rehab 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 48-year-old male who reported an injury on 08/10/2009. He was reportedly walking and got hit by a car. On 05/05/2014, the injured worker presented with neck, shoulder, lumbar, and left shoulder pain. He also reported difficulty with ejaculation. Other therapies included anti-inflammatory medication, pain medication, physical therapy, epidural steroid injections, modification of activities, median branch blocks, ACDF and disc replacement at C6-7 and C5-6, and bilateral TFESI to the L4-5 and L5-S1. Upon examination of the cervical spine, there was tenderness to palpation over the cervical facet joints; range of motion was limited secondary to pain, and a positive Spurling's test. The examination of the lumbar spine examination noted limited range of motion, pain to palpation over L4-5 and L5-S1, with palpable paraspinal muscle spasms, and a positive straight leg raise bilaterally. The diagnoses were status post ACDF C6-7 disc replacement at C5-6, disc protrusion at C5-6, mild discogenic changes at C3-4, radiculopathy of the bilateral upper extremities, facet syndrome, and cervical spine pain to palpation and limited extension of the facets. The provider requested hydrocodone/APAP 10/325 mg with a quantity of 60 and carisoprodol 350 mg with a quantity of 60. The provider's rationale was not provided. The Request for Authorization form was not included in the medical documents for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

PHARMACY PURCHASE OF HYDROCODONE/APAP 10/325 MG #120: Upheld

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

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

Decision rationale: The request for pharmacy purchase of hydrocodone/APAP 10/325 mg #120 is not medically necessary. California MTUS Guidelines recommend providing ongoing education of both the benefit and limitations of opioid treatment. The Guidelines recommend the lowest possible dose should be prescribed for pain and function. The Guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The pain assessment should include current pain, least reported pain over the period since the last assessment, average pain, intensity of pain after taking the opioid, how long it takes for pain relief, and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function or improved quality of life. The provided medical documentation lacked evidence of the injured worker's failure to respond to nonopioid analgesics. The documentation lacked evidence of the efficacy of the medication, a complete and accurate pain assessment, and aberrant behaviors. As such, the request is not medically necessary.

CARISOPRODOL 350 MG #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CARISOPRODOL (SOMA).

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

Decision rationale: The request for carisoprodol 350 mg with a quantity of 60 is not medically necessary. The California MTUS Guidelines do not recommend carisoprodol. This medication is not indicated for long-term use. Carisoprodol is a commonly prescribed centrally acting skeletal muscle relaxant whose primarily active metabolite is meprobamate. Abuse has been noted for sedative and relaxant effects. The injured worker has been prescribed carisoprodol since at least 03/2014. The efficacy of the medication was not provided. As the guidelines do not recommend carisoprodol, the medication would not be indicated. Additionally the provider's request did not indicate the frequency of the medication. As such, the request is not medically necessary.