

Case Number:	CM14-0038754		
Date Assigned:	07/25/2014	Date of Injury:	08/25/2003
Decision Date:	09/23/2014	UR Denial Date:	03/18/2014
Priority:	Standard	Application Received:	04/02/2014

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 & Rehabilitation, has a subspecialty in Pain 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 injured worker is a 69-year-old male who reported an injury on 08/25/2003. The mechanism of injury was a conveyor belt accident. His diagnosis was noted to be lumbago. Diagnostic tests include MRI of the lumbosacral spine, MRI of the cervical spine, CT scan of the cervical spine, and x-rays of the cervical spine. Surgical history was noted to be anterior cervical discectomy, C4-5, C5-6, and C6-7; partial vertebrectomy, C4-7, and fusion with allograft and anterior plate C4-7. Prior treatment was noted to be rehabilitation therapy and medication. The injured worker had a clinical evaluation on 06/23/2014. His subjective complaints were low back pain. He described his pain as throbbing, burning, sharp, hot, cold, and "sharpening." He noted numbness in both lower extremities. The objective findings were noted to be tenderness in the midline of the lower lumbar spine, particularly over a surgical scar. There was tenderness over the midline of the cervical spine. There was increased tone and trigger points in the thoracic and lumbar paraspinal muscles. Range of motion was essentially unchanged. The treatment plan was for medications and physical therapy. The rationale for the request was noted within the clinical evaluation, and a Request for Authorization form was not provided with this review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Soma 350mg #90: Upheld

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

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

Decision rationale: The request for Soma 350mg #90 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. Abuse has been noted for sedative and relaxant effects. Most treatment includes somatic complaints of withdrawal. There is little research in terms of weaning of high dose Soma and there is no standard treatment regimen for injured workers with known dependence. The documentation does not note efficacy with prior use of Soma, and the guidelines do not recommend Soma for long term use. In addition, the provider's request for Soma fails to indicate a dosage frequency. As such, the request for Soma 350mg #90 is not medically necessary.

Voltaren gel 1% #5 tubes: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Diclofenac Sodium (Voltaren).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112.

Decision rationale: The request for Voltaren gel 1% #5 tubes is not medically necessary. The California MTUS Chronic Pain Medical Treatment Guidelines do not recommend topical analgesics. These are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. FDA approved agent Voltaren gel is indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). It has not been evaluated for treatment of the spine, hip, or shoulder. The documentation submitted for review does not indicate a failed trial of antidepressant or anticonvulsant medication. In addition, the medication is not indicated for lumbar or cervical spine pain. In addition, the provider's request fails to indicate a dosage frequency. As such, the request for Voltaren gel 1% #5 tubes is not medically necessary.