

Case Number:	CM14-0050357		
Date Assigned:	08/04/2014	Date of Injury:	05/12/2008
Decision Date:	10/23/2014	UR Denial Date:	02/24/2014
Priority:	Standard	Application Received:	03/24/2014

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:

This 48 year old patient had a date of injury on 5/12/2008. The mechanism of injury was not noted. In a progress noted dated 2/20/2014, the patient complains of severe pain increase since last visit. She reports colon pain, and comes in for a medication refill. On a physical exam dated 2/20/2014, there is tenderness to palpation over cervical spine, tenderness over the flexor muscle on right elbow examination, and tenderness to palpation over lumbar spine. The diagnostic impression shows status post cervical spine anterior interbody fusion at C5, C6, C7, performed on 11/23/2010, right elbow ulnar neuropathy, right wrist median neuropathy, lumbar spine strain/sprain. Treatment to date: medication therapy, behavioral modification, surgery. A UR decision dated 2/25/2014 denied the request for Soma 350mg #90, stating no increase in function or decrease in pain was noted, and #45 would be appropriate for weaning. Topamax 50mg #90 was denied, stating no documentation of failure of other medications for neuropathic pain. Oxycontin 50mg #90 was denied, stating no documentation of increase in function or decrease in pain with this medication, and #45 would be indicated for weaning. Percocet 10/325mg #150 was denied, stating no documentation of increase in function, and #75 would be appropriate for weaning. Atarax 25mg #30 was denied, stating no documentation of increase in function. Robaxin 750mg #30 was denied, stating that there was lack of documented enhanced and /or maintained functionality, and #15 would be appropriate for weaning.

IMR ISSUES, DECISIONS AND RATIONALES

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

Soma 350mg, qty 90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 29, 65.

Decision rationale: CA MTUS states that Soma is not indicated for long-term use. Carisoprodol is a commonly prescribed, centrally-acting skeletal muscle relaxant and is now scheduled in several states. It has been suggested that the main effect is due to generalized sedation and treatment of anxiety. Abuse has been noted for sedative and relaxant effects. Soma has been known to augment or alter the effects of other medications, including opiates and benzodiazepines. However, this patient has been on soma since at least 1/8/2014, and guidelines do not support long term use. Furthermore, this patient is taking Oxycontin, and soma has been known to augment the effects of opioids. Symptoms such as respiratory depression and death can occur. Therefore, the request for Soma 350mg #90 was not medically necessary.

Topamax 50mg, qty 90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 21.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 16-21.

Decision rationale: CA MTUS Chronic Pain Medical Treatment Guidelines state that Topiramate is considered for use for neuropathic pain when other anticonvulsants fail. However, in the 2/20/2014 progress report, there was no clear evidence of a failure of a 1st line oral analgesic such as Gabapentin or Lyrica. Therefore, the request for Topomax 50mg #90 was not medically necessary.

Oxycontin 50mg, qty 90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 91.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78-81.

Decision rationale: CA MTUS Chronic Pain Medical Treatment Guidelines do not support ongoing opioid treatment unless prescriptions are from a single practitioner and are taken as directed; are prescribed at the lowest possible dose; and unless there is ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. However, in the 8/20/2014 progress report, there was no documented functional improvement noted with the opioid regimen. In fact, the patient subjectively complains of an increase in pain over last visit. Therefore, the request for Oxycontin 20mg #90 was not medically necessary.

Percocet 10/325mg, qty 150: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 91.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78-81.

Decision rationale: CA MTUS Chronic Pain Medical Treatment Guidelines do not support ongoing opioid treatment unless prescriptions are from a single practitioner and are taken as directed; are prescribed at the lowest possible dose; and unless there is ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. However, in the 2/20/2014 progress report, there was no functional improvement noted from the opioid regimen. In fact, the patient subjectively complains of an increase in pain over last visit. Therefore, the request for Percocet 10/325 #150 was not medically necessary.

Atarax 25mg, qty 30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.pdr.net/drug-summary/hydroxyzine-hydrochloride-tablets?druglabelid=741&id=1061>

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation FDA: Atarax

Decision rationale: CA MTUS and ODG do not address this issue. The FDA states that Atarax is indicated for symptomatic relief of anxiety and tension associated with psychoneurosis and as an adjunct in organic disease states in which anxiety is manifested; and is useful in the management of pruritus due to allergic conditions such as chronic urticaria and atopic and contact dermatoses, and in histamine-mediated pruritus. However, in the 2/20/2014 progress report, there was no documentation of functional improvement noted with Atarax, and this patient has been on Atarax since at least 1/8/2014. Therefore, the request for Atarax 25mg #30 was not medically necessary.

Robaxin 750mg, qty 30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63-66.

Decision rationale: CA MTUS Chronic Pain Medical Treatment Guidelines, state that muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in most LBP cases, they show no benefit beyond NSAIDs in pain and overall

improvement, and no additional benefit has been shown when muscle relaxants are used in combination with NSAIDs. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. However, in the 2/20/2014 progress report, the patient reports an increase in pain, and the patient is documented to be on Robaxin since at least 1/8/2014. Therefore, the request for Robaxin 750mg #30 was not medically necessary.