

<b>Case Number:</b>	CM14-0060815		
<b>Date Assigned:</b>	07/09/2014	<b>Date of Injury:</b>	06/01/1998
<b>Decision Date:</b>	09/29/2014	<b>UR Denial Date:</b>	04/14/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/01/2014

### 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, has a subspecialty in Pain Medicine and is licensed to practice in Texas and Oklahoma. 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 47-year-old female who reported an injury on 06/01/1998. The mechanism of injury was from lifting patients. The diagnoses included thoracic postlaminectomy syndrome, degeneration of thoracic intervertebral disc, pain in thoracic spine, non-allopathic lesion of the thoracic region. The previous treatments included medication and physical therapy. The diagnostic testing included a computed tomography scan of the spine and ribs, electrocardiogram/nerve conduction velocity and x-rays. Within the clinical note dated 02/18/2014 it was reported the injured worker complained of back pain and thoracic pain. The injured worker rated her pain 7/10 in severity. She described the pain as itching, cramping, tightness and constant. Upon the physical examination the provider noted the injured worker to have tenderness noted over the paraspinal muscle overlaying the facet joints on the right side. The range of motion of the cervical spine was within normal limits except for the left rotation which is limited to 60 degrees with pain. The injured worker had tenderness to palpation of the cervical spine noted over the paraspinal muscles. The medication regimen included Amerge, Flonase, Metaxalone, MetroCream, Norco, Soma, Tramadol, and Carisoprodol. The provider requested for Carisoprodol, and Norco. However, a rationale was not provided for clinical review. The Request for Authorization was not provided for clinical review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Carisoprodol 350mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 65.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63, 64.

**Decision rationale:** The request for Carisoprodol 350 mg #60 is not medically necessary. The California MTUS Guidelines recommend non-sedating muscle relaxants with caution as a second line option for short term treatment of acute exacerbation in patients with chronic low back pain. The guidelines note the medication is not recommended to be used for longer than 2 to 3 weeks. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. Additionally, the injured worker has been utilizing the medication since at least 02/2014 which exceeds the guideline recommendations of short term use of 2 to 3 weeks. Therefore, the request is not medically necessary.

**Norco 10-325mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for osteoarthritis Page(s): 83. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Opioids.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use, On-Going Management Page(s): 78.

**Decision rationale:** The request for Norco 10/325 #60 is not medically necessary. The California MTUS Guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The guidelines recommend the use of a urine drug screen or inpatient treatment with issues of abuse, addiction, or pain control. The provider failed to document an adequate and complete pain assessment within the documentation. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. Additionally, the use of a urine drug screen was not provided for clinical review. Therefore, the request is not medically necessary.