

Case Number:	CM14-0073561		
Date Assigned:	07/16/2014	Date of Injury:	03/17/2009
Decision Date:	09/24/2014	UR Denial Date:	05/14/2014
Priority:	Standard	Application Received:	05/20/2014

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 Anesthesiology, has a subspecialty in Pain Management 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:

According to the records made available for review, this is a 55-year-old female with a 3/17/09 date of injury. At the time (4/29/14) of request for authorization for Soma 350mg 1 Tablet TID For 30 Days #90 X3 Refills, Ibuprofen 800mg Tablet 1 Q8h Pm For 30 Days #90 X3 Refills, Lamictal 25mg Tablet 1 QHS PRN For 30 Days #30 X3 Refills, Paxil 20mg Tablet 1 QAM PM for 30 Days #30 X3 Refills, and Buprenorphine 8mg sublingual tablet TID PM PRN for 30 Days #90 X3 Refills, there is documentation of subjective (pain in neck, back, pain radiates to left arm, pain 9/10 at its worst, and 6/10 on average) and objective (increased tone and pain to palpation of cervical paraspinal, scalenes, splenius capitis, splenius cervicis, levator scapula, trapezius, and rhomboid muscles, hyperirritable spots with palpable nodules in taut bands noted, pain with cervical range of motion, positive facet loading pain, lumbar paraspinal tenderness, abnormal paraspinal bulk bilaterally, increased paraspinal tone bilaterally, palpation of lumbar facets revealed pain on both sides of L3-S1 region, decreased sensation to light touch and pinprick in right L5 and S1 dermatomal distribution, positive straight leg raise bilaterally, and patella and Achilles reflexes 1+ bilaterally) findings, current diagnoses (lumbar/thoracic radiculopathy, insomnia, myofascial pain syndrome, depression due to chronic pain, cervical radiculopathy, lumbar facet spondylosis, and occipital neuralgia), and treatment to date (medications (including Soma since at least 11/18/13, Ibuprofen, Robaxin, Lamictal, Paxil, Seroquel, Ambien, and Buprenorphine)). Regarding Soma 350mg 1 Tablet TID For 30 Days #90 X3 Refills, there is no documentation of acute muscle spasms, the intention to treat over a short course, and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Soma use to date. Regarding Lamictal 25mg Tablet 1 QHS PRN for 30 Days #30 X3 Refills, there is no documentation that Lamictal is second line treatment and functional benefit or improvement as a reduction in work restrictions;

an increase in activity tolerance; and/or a reduction in the use of medications as a result of Lamictal use to date. Regarding Paxil 20mg Tablet 1 QAM PM for 30 Days #30 X3 Refills, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Paxil use to date. Regarding Bupreorphine 8mg sublingual tablet TID PM PRN for 30 Days #90 X3 Refills, there is no documentation of detoxification in patients who have a history of opiate addiction and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Bupreorphine use to date.

IMR ISSUES, DECISIONS AND RATIONALES

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

Soma 350mg 1 Tablet Tid For 30 Days #90 X3 Refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Soma Page(s): 29. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Muscle relaxants (for pain).

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies that Carisoprodol (Soma) is not recommended and that this medication is not indicated for long term use. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. ODG identifies that muscle relaxants are recommended as a second line option for short-term (less than two weeks) treatment of acute low back pain and for short-term treatment of acute exacerbations in patients with chronic low back pain. Within the medical information available for review, there is documentation of diagnoses of lumbar/thoracic radiculopathy, insomnia, myofascial pain syndrome, depression due to chronic pain, cervical radiculopathy, lumbar facet spondylosis, and occipital neuralgia. However, there is no documentation of acute muscle spasms. In addition, given documentation of records reflecting prescriptions for Carisoprodol/Soma since at least 11/18/13, there is no documentation of the intention to treat over a short course (less than two weeks). Furthermore, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Soma use to date. Therefore, based on guidelines and a review of the evidence, the request for Soma 350mg 1 Tablet TID for 30 Days #90 X3 Refills is not medically necessary.

Lamictal 25mg Tablet 1 Qhs Prn For 30 Days #30 X3 Refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti epileptic Page(s): 20.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lamotrigine (Lamictal) Page(s): 20.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of neuropathic pain, as criteria necessary to support the medical necessity of Lamotrigine (Lamictal). In addition, MTUS Chronic Pain Medical Treatment Guidelines identifies that Lamictal is not recommend as first line treatment. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of lumbar/thoracic radiculopathy, insomnia, myofascial pain syndrome, depression due to chronic pain, cervical radiculopathy, lumbar facet spondylosis, and occipital neuralgia. In addition, there is documentation of neuropathic pain. However, there is no documentation that Lamictal is second line treatment. In addition, given documentation of ongoing treatment with Lamictal, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Lamictal use to date. Therefore, based on guidelines and a review of the evidence, the request for Lamictal 25mg Tablet 1 QHS PRN for 30 Days #30 X3 Refills is not medically necessary.

Paxil 20mg Tablet 1 qam PM for 30 Days #30 X3 Refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain Page(s): 13-14. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness and Stress Chapter, Antidepressants.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of chronic pain, as criteria necessary to support the medical necessity of antidepressants. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. ODG identifies documentation of depression, as criteria necessary to support the medical necessity of antidepressants. Within the medical information available for review, there is documentation of diagnoses of lumbar/thoracic radiculopathy, insomnia, myofascial pain syndrome, depression due to chronic pain, cervical radiculopathy, lumbar facet spondylosis, and occipital neuralgia. In addition, there is documentation of chronic pain and depression. However, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a

result of Paxil use to date. Therefore, based on guidelines and a review of the evidence, the request for Paxil 20mg Tablet 1 QAM PM for 30 Days #30 X3 Refills is not medically necessary.

Bupreorphine 8mg sublingual tablet tid PM prn for 30 Days #90 X3 Refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 26.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Buprenorphine Page(s): 26-27.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of opiate addiction or chronic pain (after detoxification in patients who have a history of opiate addiction), as criteria necessary to support the medical necessity of Buprenorphine. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of lumbar/thoracic radiculopathy, insomnia, myofascial pain syndrome, depression due to chronic pain, cervical radiculopathy, lumbar facet spondylosis, and occipital neuralgia. In addition, there is documentation of chronic pain. However, there is no documentation of detoxification in patients who have a history of opiate addiction. In addition, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Bupreorphine use to date. Therefore, based on guidelines and a review of the evidence, the request for Bupreorphine 8mg sublingual tablet tid PM prn for 30 Days #90 X3 Refills is not medically necessary.