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| Case Number: | CM14-0075825 | | |
| Date Assigned: | 07/16/2014 | Date of Injury: | 10/25/1999 |
| Decision Date: | 09/17/2014 | UR Denial Date: | 05/15/2014 |
| Priority: | Standard | Application Received: | 05/24/2014 |

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:

The underlying date of injury in this case is 10/25/2009. The patient's treating diagnosis is lumbar radiculopathy with a history of past surgery. On 04/29/2014, the patient was seen primary treating physician follow-up and reported ongoing continued back pain. No new neurological deficits were noted on examination. The treating physician recommended continuation of Carisoprodol, Hydrocodone, and Capsaicin cream and indicated a plan for an independent medical review given past denied treatments.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hydrocodone (Norco-5-325) tablet take 1 twice daily #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78-79.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for Chronic Pain Page(s): 80.

Decision rationale: The Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines section on opioids for chronic pain, page 80, does not recommend opioids for chronic pain, particularly for the low back and particularly without clear documentation of functional benefit requiring such opioid treatment. The records do not provide an alternate

rationale to support the request. Overall this request is not supported by the treatment guidelines. This request is not medically necessary.

Capsaicin 0.025% cream, apply twice a day as directed: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines topical analgesics Page(s): 112.

Decision rationale: The Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines section on topical analgesics, page 112, states that capsaicin is recommended only in patients who have not responded to or are intolerant to other treatments. The medical records contain very limited information to document such intolerance of past treatment or the rationale as to why this treatment is indicated. This request is not medically necessary.

Carisoprodol 350mg tablet 1 twice daily, #60 with 2 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol Page(s): 64-65.

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

Decision rationale: The Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines section on Carisoprodol/Soma, page 29, discusses at length concerns regarding the use of this medication particularly in a chronic setting. This medication has considerable potential for abuse, and the records and guidelines do not provide a rationale as to why this medication would instead be indicated. This is not supported by the treatment guidelines. This request is not medically necessary.