

Case Number:	CM14-0081608		
Date Assigned:	07/18/2014	Date of Injury:	12/02/1994
Decision Date:	08/25/2014	UR Denial Date:	05/06/2014
Priority:	Standard	Application Received:	06/02/2014

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 and Rehabilitation and is licensed to practice in Alabama. 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 patient is a 52 year old female who was injured on 12/02/1994. The mechanism of injury is unknown. Prior treatment history has included home exercise program, nerve block/injections, physical therapy, TENS, acupuncture, and medications. Prior medication history included Capsule Nortriptyline, Roxicodone 30 mg, Soma 350 mg tablet, Trazodone Hcl 100 mg. The patient underwent left ulnar surgery and right arm surgery twice. (date unknown). Diagnostic studies reviewed include drug panel dated 03/03/2014 revealed positive results for opiates. Progress report dated 04/24/2014 indicated the patient complained of worsening left arm pain with numbness in his wrist, thumb and ring finger. He reported using his right arm more than his left because of the disability of his left arm. He has right elbow sensitivity and numbness at the 4th and 5th digits. He rated his pain as 7/10 at its best and a 9/10 at its worse. He described symptoms of sharp pain, stabbing, burning pain. He reported his pain is aggravated by the cold weather, activity and walking and is alleviated by heat, rest, and medication. Objective findings on exam revealed right upper extremity is 5/5 muscle strength and left shoulder revealed 4+/5 strength in left triceps and left wrist extensors; 3+/5 left handgrip and left interossei. Bilateral lower extremities revealed 5/5 muscle strength. Deep tendon reflexes are 2+. Assessments are moderate depressive disorder, anxiety disorder, and sympathetic reflex dystrophy. She was recommended Roxicodone 30 mg #120, Soma 350 mg #90, and Trazodone hcl 100 mg. Prior utilization review dated 05/06/2014 states the request for Soma 350 mg #90 and Roxicodone 30 mg #120 has been modified to Soma 350 mg #60 and Roxicodone 30 mg #90 for tapering and weaning purposes.

IMR ISSUES, DECISIONS AND RATIONALES

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

Soma #90: Overturned

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol (Soma, Soprodal 350, Vanadom, generic available) Page(s): 65. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain, Carisoprodol (Soma®).

Decision rationale: The above ODG guidelines state that Carisoprodol is not recommended. This medication is not indicated for long-term use. Weaning: Tapering should be individualized for each patient. In this case, although the patient is no longer indicated for continued use of Carisoprodol because the patient has been on this medication since at least 10/17/13, the patient requires a weaning taper for the medical safety. The decision for soma is medically necessary for this final prescription to be used as a weaning prescription and no further prescriptions for Carisoprodol. Therefore, based on the above guidelines and criteria as well as the clinical documentation stated above, the request is medically necessary.

Roxicodone #120: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Oxycodone immediate release (OxyIR capsule; Roxicodone tablets; generic available), Oxycodone controlled release (OxyContin) Page(s): 92. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain, Opioids.

Decision rationale: The above CA MTUS and ODG state that on-going management of opioids require ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects... Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Weaning should occur under direct ongoing medical supervision as a slow taper. The patient should not be abandoned. In this case, although the patient is no longer indicated for continued use of opioids because there is no documented history of the above criteria, the patient has been on this medication since at least 10/17/13, thus the patient requires a weaning taper for the medical safety. The decision for Roxicodone is medically necessary for this final prescription to be used as a weaning prescription and no further prescriptions for opioids. Therefore, based on the above guidelines and criteria as well as the clinical documentation stated above, the request is medically necessary.