

Case Number:	CM14-0105007		
Date Assigned:	07/30/2014	Date of Injury:	02/25/2002
Decision Date:	07/01/2015	UR Denial Date:	06/13/2014
Priority:	Standard	Application Received:	07/08/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: Iowa, Illinois, Hawaii

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & General Preventive Medicine

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 64-year-old male, who sustained an industrial injury on February 25, 2002. He reported an injury to his lumbar spine. Treatment to date has included EMG/NCV of the bilateral lower extremities, medications, and lumbar microdiscectomy. An evaluation on June 5, 2014 revealed the injured worker continued to have low back pain with radiculopathy into his left lower extremity. An EMG/NCV of the lower extremities confirmed radiculopathy in the bilateral lower extremities. On physical examination, the injured worker has pain with palpation and multiple trigger points and muscle guarding of the lumbar spine. His range of motion is reduced and restricted and he ambulated with an antalgic gait. The injured worker has a positive straight leg raise test on the left. The diagnoses associated with the request include chronic low back pain, facet joint arthropathy and sleep disorder. The treatment plan includes pain management consultation, hydrocodone and carisoprodol.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hydrocodone BIT/ Acetaminophen 10/325mg, #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Hydrocodone, Opioids Page(s): 51, 74-96.

Decision rationale: ODG does not recommend the use of opioids for low back pain "except for short use for severe cases, not to exceed 2 weeks." The patient has exceeded the 2 week recommended treatment length for opioid usage. MTUS does not discourage use of opioids past 2 weeks, but does state that "ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life." The treating physician does not fully document the least reported pain over the period since last assessment, intensity of pain after taking opioid, pain relief, increased level of function, or improved quality of life. Additionally, medical documents indicate that the patient has been on an opioid since 2013, in excess of the recommended 2-week limit. The treating physician does not detail sufficient information to substantiate the need for continued opioid medication. Prior utilization reviews have noted the need for tapering and weaning. As such, the request for Hydrocodone BIT/ Acetaminophen 10/325mg, #90 is not medically necessary.

Soma 350mg, #40: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol (Soma) and Muscle relaxants (for pain) Page(s): 29, 63-66. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain, Soma (Carisoprodol).

Decision rationale: MTUS states regarding Crisoprodol, "Not recommended. This medication is not indicated for long-term use. Carisoprodol is a commonly prescribed, centrally acting skeletal muscle relaxant whose primary active metabolite is meprobamate (a schedule-IV controlled substance). Carisoprodol is now scheduled in several states but not on a federal level. 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. In regular abusers, the main concern is the accumulation of meprobamate. Carisoprodol abuse has also been noted in order to augment or alter effects of other drugs." ODG States that Soma is "Not recommended. This medication is FDA-approved for symptomatic relief of discomfort associated with acute pain in musculoskeletal conditions as an adjunct to rest and physical therapy (AHFS, 2008). This medication is not indicated for long-term use." The patient has been on the medication in excess of guideline recommendations. Guidelines do not recommend long-term usage of SOMA. Treating physician does not detail circumstances that would warrant extended usage. As such, the request for Soma 350mg, #40 is not medically necessary.