MAXIMUS Federal Services

Case Number:	CM14-0015896		
Date Assigned:	04/09/2014	Date of Injury:	03/31/2006
Decision Date:	03/12/2015	UR Denial Date:	01/06/2014
Priority:	Standard	Application Received:	02/07/2014

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: California, Arizona
Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 51-year-old male who reported an injury on 03/31/2006. The mechanism of injury was not submitted for review. The injured worker has a diagnosis of status post-surgical repair of the left shoulder, primarily of rotator cuff and status post-surgery of the left knee. Past medical treatment consists of surgery, therapy, and medication therapy. Medications include ibuprofen 800 mg, Soma 350 mg, tramadol 37.5/325 mg, gabapentin 600 mg. No UAs or drug screens were submitted for review. On 12/13/2013, the injured worker was seen for a follow-up and complained of ongoing right shoulder, bilateral knee, and left shoulder pain. He also complained of some mild low back pain. Physical examination revealed tenderness in both shoulders, with right being greater than left. There was near full range of motion in both shoulders. The left knee was tender greater than the right. No effusion was noted in either knee. The left knee range of motion was 0 degrees extension, 100 degrees of flexion. The right knee had full range of motion. Right shoulder internal derangement secondary to injury to the left shoulder. Right knee internal derangement secondary to altered gait from the left knee. Medical treatment plan is for the injured worker to continue with medication therapy. Rationale was not submitted for review. Request for Authorization form was submitted on 12/13/2013.

IMR ISSUES, DECISIONS AND RATIONALES

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

RETROSPECTIVE REQUEST FOR SOMA 350MG #90 (DOS 12-13-13): 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 Page(s): 29, 65.

Decision rationale: The request for retrospective request for soma 350mg #90 (DOS 12-13-13) is not medically necessary. The California MTUS Guidelines state Soma is not indicated for longer than 2 to 3 weeks. Carisoprodol (Soma) is commonly prescribed, centrally acting skeletal muscle relaxant. 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. Soma abuse has also been noted in order to augment or alter effects of other drugs. A withdrawal syndrome has been documented that consists of insomnia, vomiting, tremors, muscle twitching, anxiety, ataxia, when discontinuation of large doses occurs. The submitted documentation did not indicate the efficacy of the medication, nor did it indicate any evidence of muscle twitch, which would indicate the use of Soma. Additionally, it was indicated that the injured worker had been on the medication since at least 06/28/2013, exceeding recommended guidelines for short term course therapy of 2 to 3 weeks. Furthermore, the request as submitted was for Soma 350 mg #90, also exceeding guideline recommendations. Given the above, the request would not have been indicated. As such, the request was not medically necessary.

RETROSPECTIVE REQUEST FOR TRAMADOL 37.5/325MG, #90 (DOS: 12-13-13): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol, Ongoing management Page(s): 82, 93, 94, 113, 78.

Decision rationale: The request for retrospective request for tramadol 37.5/325MG, #90 (DOS: 12-13-13) is not medically necessary. The California MTUS Guidelines state that central analgesic drugs, such as tramadol, are reported to be effective in managing neuropathic pain, and are not recommended as first line oral analgesic. California MTUS recommended that there should be documentation of the 4 A's for ongoing monitoring, including analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors. The submitted documentation did indicate the efficacy of the medication, nor did it indicate that the medication was helping with any functional deficits the injured worker was having. There was no documentation of activities of daily living increase or functional improvement. Furthermore, there were no UAs or drug screens submitted for review showing that the injured worker was compliant with prescription medications. Given the above, the medication would not have been indicated. As such, the request was not medically necessary.