

Case Number:	CM15-0000402		
Date Assigned:	01/12/2015	Date of Injury:	05/16/2013
Decision Date:	03/11/2015	UR Denial Date:	12/09/2014
Priority:	Standard	Application Received:	01/02/2015

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

Certification(s)/Specialty: Family Practice

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This 41 year old foreman reported a right shoulder injury after a fall on 05/16/13. Diagnoses that have been added with time include injury to the right long thoracic nerve and cervical radiculopathy. Treatment has included medications, physical therapy, and a shoulder surgery on 10/1/13 with a revision on 4/17/14. Per the physician notes from 11/25/14 the patient continues to have right shoulder and neck pain in addition to pain, numbness, and tingling radiating down his arm and into his fingers which is worsening. His medications include Percocet, Soma and ibuprofen. Documented diagnoses include brachial plexus disorder, fibromyositis, psychophysiological disorder, adhesive capsulitis of shoulder, disorder of bursa of shoulder, and cervical radiculopathy. The treatment plan includes an epidural steroid injection, isotonic strengthening with band, EMG, continued physical therapy, Percocet and Soma. A review of the records reveals that the patient has been taking Percocet 10/325 five times per day since at least 7/30/14, and Soma 350 mg 1-2 at bedtime since at least 10/23/14. The rationale most often documented for the use of Percocet is "increased pain due to post-operative rehabilitation". Soma was apparently begun after ongoing Ativan was denied in UR. The rationale given for the use of Soma was "for acute muscle spasm". Requests for Percocet have been modified to a smaller number than requested (to allow for weaning) four times in UR: on 7/30/14, 10/30/14, 12/19/14 and 1/9/15. Soma was similarly modified on 10/30/14 and non-certified on 12/19/14. The patient's work status has remained totally disabled. Many of the progress notes contain the same non-specific functional goals: that the patient is to "do patient-specific home exercise every day" and that he is to "increase walking distance and stretch afterward". There is no record

of increasing ability to specific exercises, or of any increase in distance walked. On 12/09/14 Percocet was modified from a quantity of 150 to 60 and Soma was non-certified in UR. MTUS Chronic Pain Opioids, and MTUS Chronic Pain Carisoprodol references were cited as the basis for the decisions.

IMR ISSUES, DECISIONS AND RATIONALES

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

Percocet 10/325mg #150: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain, page 60; Criteria for use of Opioids, pages 76-77; Opioids for neu.

Decision rationale: Oxycodone is an opioid analgesic that is only available in the U.S. in combination with another analgesic, typically acetaminophen. The form of oxycodone being requested in this case is oxycodone 10 mg combined with 325 mg of acetaminophen, for which the common brand name is Percocet 10/325. According to the first guideline cited above, medications should be started individually while other treatments are held constant, with careful assessment of function. There should be functional improvement with each medication in order to continue it. The remaining guidelines state that opioids should not be started without an evaluation of the patient's current status in terms of pain control and function. An attempt should be made to determine if the patient's pain is nociceptive or neuropathic. Red flags indicating that opioid use may not be helpful should be identified, as should risk factors for abuse. Specific goals should be set, and continued use of opioids should be contingent on meeting these goals. Opioids should be discontinued if there is no improvement in function or if there is a decrease in function. Opioids are not recommended as first-line therapy for neuropathic pain. The response of neuropathic pain to drugs may depend on the cause of the pain. There are very limited numbers of studies that involve opioid treatment for chronic lumbar root pain. A recent study found that chronic radicular lumbar pain did not respond to opioids in doses that have been effective for painful diabetic neuropathy and postherpetic neuralgia. The clinical findings in this case do not demonstrate that any of the above guidelines have been followed. There is no documentation that Percocet was introduced individually, with ongoing careful assessment of function. There is no documentation of evaluation of whether or not the patient's pain is nociceptive or neuropathic. In fact, the description of the patient's pain and the diagnoses of cervical radiculopathy and long thoracic nerve injury make it likely that the patient's pain is primarily neuropathic. Neuropathic pain does not necessarily respond well to opioids. There is no documented assessment from the current treater as to whether or not opioid use was likely to be helpful in this patient, or of his potential for abuse. No specific functional goals were set or followed. Percocet was not discontinued when it became clear that it has not produced any functional improvement. There is no specific documentation of any improvement in this patient's level of function over at least a 6-month period. This patient appears to remain unable to work in any capacity, which implies profound functional limitations. This is more than adequate evidence that this patient is not responding appropriately to this medication, and that it

should be discontinued. It is of concern that UR has modified requests for Percocet four times now, and the treating physician has apparently ignored the modifications and continued Percocet without any attempts to wean it. At this point it is most medically appropriate to non-certify it altogether. Based on the MTUS Guidelines cited above and the clinical information provided for my review, Percocet 10/325 # 150 is not medically necessary. It is not medically necessary because there is no documentation of an appropriate assessment for opioid use, because no functional goals have been set or are being followed, and because the patient appears to have made no significant functional improvement despite taking Percocet for months.

Soma 350mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol Page(s): 29.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain, page 60; Carisoprodol, page 29 Page(s): 60,29.

Decision rationale: Soma is brand-name carisoprodol, which is a centrally acting skeletal muscle relaxant. According to the first guideline cited above, medications should be started individually while other treatments are held constant, with careful assessment of function. There should be functional improvement with each medication in order to continue it. The second guideline states that carisoprodol is not recommended, and is not indicated for long-term use. Its primary metabolite, meprobamate, is a controlled substance. Carisoprodol has substantial abuse potential. It also may augment the effects of other drugs including benzodiazepines and hydrocodone. Some abusers claim that the combination of carisoprodol and hydrocodone produces effects that are similar to those of heroin. The records in this case reveal that this patient has been on Soma for at least three months, which would not constitute short term use. There is documented evidence that Soma has improved his level of function in any way. Given its sedating effects, especially in combination with Percocet, it seems likely that Soma may actually be contributing to this patient's low functional level. Taking the evidence-based guidelines cited above and the clinical findings in this case into account, Soma 350 mg #50 is not medically necessary. It is not medically necessary because it is not recommended by MTUS guidelines, because it should not be taken long-term, and because its use has not resulted in any functional improvement in this patient and may in fact be contributing to his ongoing low level of function.