

Case Number:	CM15-0005305		
Date Assigned:	01/16/2015	Date of Injury:	08/03/2009
Decision Date:	04/03/2015	UR Denial Date:	12/11/2014
Priority:	Standard	Application Received:	01/09/2015

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, 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 48-year-old male who reported an injury on 08/30/2009 due to an unspecified mechanism of injury. On 02/03/2014, he presented for a follow up evaluation regarding his work related injury. He reported 5/10 low back pain with left greater than right lower extremity symptoms and continued to complain of further decline in his activity and function. He also reported 6/10 right shoulder and left shoulder pain. His medications included hydrocodone 10 mg, Soma 350 mg, Ambien 10 mg, and Zoloft 50 mg. He denied any side effects from his medications. A physical examination showed tenderness to the lumbar spine with no infection, a well healed incision, and limited range of motion with pain. Spasm of the lumbar paraspinal musculature was also noted to be decreased. He was diagnosed with status post remote lumbar decompression, 3 mm protrusion in the lumbar spine with neural encroachment and radiculopathy, and postoperative scar tissue with nerve involvement. The treatment plan was for hydrocodone and Soma. The rationale for treatment was not provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hydrocodone 10/325 mg, 120 count: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78 and 91.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines On-Going management Page(s): 78.

Decision rationale: The California MTUS Guidelines indicate that an ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should be performed during opioid therapy. The documentation provided does not show that the injured worker was having a quantitative decreased in pain or an objective improvement in function to support the request of this medication. Also, there is a lack of documentation showing that he has been screened for aberrant drug taking behaviors with urine drug screens or CURES reports. Furthermore, the frequency of the medication was not stated within the request. Therefore, the request is not supported. As such, the request is not medically necessary.

Some 350 mg, ninety count: Upheld

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

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

Decision rationale: The California MTUS Guidelines do not support the use of Soma and state that this medication is not recommended and is not indicated for long term use. Further clarification is needed regarding how long the injured worker has been using Soma for treatment. Without knowing the exact duration of treatment, continuing would not be supported as it is only recommended for short term treatment if used at all. Also, the frequency of the medication was not stated within the request and this medication is not supported for use by the cited guidelines. Therefore, the request is not supported. As such, the request is not medically necessary.