

Case Number:	CM15-0101942		
Date Assigned:	06/04/2015	Date of Injury:	06/25/2006
Decision Date:	07/09/2015	UR Denial Date:	04/27/2015
Priority:	Standard	Application Received:	05/27/2015

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: Colorado

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:

The injured worker is a 48-year-old male who sustained an industrial injury on 6/25/06. The mechanism of injury is unclear. He currently continues with chronic neck and back pain. He had a recent low back irritation and is stiff. He still suffers from chronic insomnia but getting some relief from therapeutics. On physical exam, there was moderate paralumbar myospasm and paracervical myospasm and tenderness chronically. Medications have good effect on ability to function. Medications are Norco, Soma, temazepam, Prilosec and ibuprofen, and Toradol is requested for monthly injection x 6 months. Diagnoses include calcifying tendinitis of the shoulder; non-allopathic lesion of the thoracic region; neck sprain/ strain; headache. In the progress note, dated 4/14/15 the treating provider's plan of care includes Toradol for acute pain; ibuprofen; temazepam as needed for sleep; Soma as needed for spasms; and Prilosec.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ibuprofen: Upheld

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 Pain Interventions and Treatments Page(s): 22 and 68.

Decision rationale: Per the MTUS Guidelines, non-steroidal anti-inflammatory drugs are recommended as second line agents for pain, after trial of Acetaminophen, (particularly for those patients at risk for gastrointestinal events, cardiac events, and renal disease), to be taken at the lowest effective dose for shortest period of time. Non-steroidal anti-inflammatory drugs may be first line for moderate to severe pain, based on available evidence, though studies cannot consistently confirm that non-steroidal anti-inflammatory drugs are superior to Acetaminophen. There is no evidence that any of the non-steroidal anti-inflammatory drugs are effective long term for pain relief or functional improvement. There is no consistent evidence that non-steroidal anti-inflammatory drugs are useful for long-term management of neuropathic pain. For the patient of concern, there is no documentation of functional improvement using a clinical tool to measure improvement, and no lasting/objectively rated pain relief from his current regimen, which includes Ibuprofen x 6 months or more. (No pain ratings in the record) Without objective findings of improvement, non-steroidal anti-inflammatory drugs should not be continued long term, given the risk profile. There is also no documentation indicating patient ever tried Acetaminophen prior to non-steroidal anti-inflammatory drugs. The Ibuprofen therefore is not medically necessary.

Prilosec: Upheld

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 Pain Interventions and Treatments Page(s): 68.

Decision rationale: Per the MTUS Guidelines, Prilosec and other Proton pump inhibitors can be indicated for use with non-steroidal anti-inflammatory drugs, in those at high risk for gastrointestinal events, or in those on high dose / multiple medications that increase risk of gastrointestinal events. To determine if a patient is at risk for adverse gastrointestinal events, the guidelines establish criteria to consider: (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA). For the patient of concern, who is 48 years old, the records do not indicate any diagnosis that would warrant Prilosec use. Patient does take non-steroidal anti-inflammatory drug, but the records do not mention gastrointestinal symptoms associated, or a history of gastrointestinal symptoms. Patient has had LapBand procedure, which could increase his risk of gastrointestinal events. Regardless, as the Ibuprofen is not being approved for long-term use, the request for Prilosec is not medically necessary.

Toradol injection: Upheld

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 Pain Interventions and Treatments Page(s): 22 and 68. Decision based on Non-MTUS Citation <http://www.nlm.nih.gov/medlineplus/druginfo>.

Decision rationale: Per the MTUS Guidelines, non-steroidal anti-inflammatory drugs are recommended as second line agents for pain, after trial of Acetaminophen, (particularly for those patients at risk for gastrointestinal events, cardiac events, and renal disease), to be taken at the lowest effective dose for shortest period of time. Non-steroidal anti-inflammatory drugs may be first line for moderate to severe pain, based on available evidence, though studies cannot consistently confirm that non-steroidal anti-inflammatory drugs are superior to Acetaminophen. There is no evidence that any of the non-steroidal anti-inflammatory drugs are effective long term for pain relief or functional improvement. There is no consistent evidence that non-steroidal anti-inflammatory drugs are useful for long-term management of neuropathic pain. Toradol Injection is indicated for acute pain or acute exacerbation of an underlying chronic condition. Per the records, patient received a Toradol injection at 4/14/2015 office visit for increased neck pain, which was resulting in severe headache. The treating physician then requested monthly injections of Toradol x 6 months April 2015. Those injections were denied, and the application for this review did not specify number or frequency of injections, so the request is unclear. While the initial Toradol injection may have been medically indicated for patient's acute exacerbation of his underlying neck issues causing headache, additional monthly Toradol injections would not be medically indicated given that Toradol is only to be used in acute pain settings, and 6 months of use is by definition chronic. As the request is not specific, and recurrent use of Toraol injection is not indicated, the request for Toradol injection is not medically necessary.

Temazepam: Upheld

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 Pain Interventions and Treatments Page(s): 24.

Decision rationale: Benzodiazepines are not recommended for long-term use. Per the guidelines, benzodiazepines can be used short term, no more than 4 weeks, in chronic pain, and in other indications including sedative/hypnotic, anxiolytic, anti-epileptic, and muscle relaxation. Chronic benzodiazepine use is rarely indicated, and can make symptoms worse over time. Tolerance to the anxiolytic and sedative properties of benzodiazepines develops within first few months of use. Per the records supplied, the patient has been taking Temazepam for years, with waxing and waning efficacy documented. Furthermore, the patient's Insomnia issues are documented as related to his shift work cycle, not his industrial injury so would not be covered under this system regardless. As Temazepam is not recommended for long-term use and as patient has equivocal improvement with the medication and tolerance/dependence over time, the request for Temazepam is not medically necessary. Patient should not abruptly discontinue the Temazepam.

Soma: Upheld

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 Pain Interventions and Treatments Page(s): 29, 63, and 65.

Decision rationale: Per the Guidelines, muscle relaxants, comprised of anti-spasmodics and anti-spasticity drugs, can be recommended as second line, short-term options for treatment of low back pain. Studies suggest that muscle relaxants can decrease pain and muscle tension, thereby improving mobility / flexibility. However, the studies do not show any benefit of muscle relaxants over non-steroidal anti-inflammatory drugs, or in combination with non-steroidal anti-inflammatory drugs, for low back pain. The effects of muscle relaxants appear to decrease over time, and none of the anti-spasmodics are recommended for use longer than 2-3 weeks. Long-term use of some of the muscle relaxants, including Carisoprodol (Soma), may result in dependence. While Carisoprodol is one of the most commonly prescribed muscle relaxants, it is not recommended for use per the Guidelines, due to its potential for abuse. Carisoprodol is metabolized to meprobamate, a schedule IV substance. Carisoprodol is abused for its own effects, but it has also been shown to alter the effects of other drugs such as: (1) increasing sedation of benzodiazepines or alcohol; (2) use to prevent side effects of cocaine; (3) use with tramadol to produce relaxation and euphoria; (4) as a combination with hydrocodone, an effect that some abusers claim is similar to heroin (referred to as a "Las Vegas Cocktail"); and (5) as a combination with codeine (referred to as "Soma Coma"). (Reeves, 1999) (Reeves, 2001) (Reeves, 2008) (Schears, 2004) There was a 300% increase in numbers of emergency room episodes related to carisoprodol from 1994 to 2005. (DHSS, 2005) Carisoprodol has also been shown to have a withdrawal syndrome characterized by insomnia, vomiting, tremor, muscle twitches, anxiety, and ataxia, with no known treatment for patients with dependence. Carisoprodol was approved before FDA required proof of efficacy and safety. Based on the Guidelines, Carisoprodol (Soma) is not a recommended medication for use in pain management. The request for Soma is not medically necessary.