

Case Number:	CM15-0202367		
Date Assigned:	10/19/2015	Date of Injury:	03/08/2011
Decision Date:	12/01/2015	UR Denial Date:	09/24/2015
Priority:	Standard	Application Received:	10/14/2015

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: Washington, California

Certification(s)/Specialty: Preventive Medicine, Occupational 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 37 year old female with an industrial injury dated 03-08-2011. A review of the medical records indicates that the injured worker is undergoing treatment for disc herniation syndrome and spinal discopathy along with significant pain and left sided L4-5 and L5-S1 herniated nucleus pulposus status post-laminectomy and discectomy. She is not working. X-ray of the lumbar spine performed on 07-31-2015 did not reveal any instability. Lumbar Magnetic Resonance Imaging (MRI) dated 07-30-2015 revealed mild to moderate degenerative disc disease at L4-5 and L5-S1, which has slightly progressed at L4-5. Electrodiagnostic study of the bilateral lower extremities on 7-24-2015 was normal. Treatment has included diagnostic studies, medications, acupuncture, lumbar epidural steroid injection (ESI), physical therapy and periodic follow up visits. According to the progress note dated 09-04-2015, the injured worker reported ongoing low back pain and lower extremity radiating symptoms and a continued complaint of difficulty sleeping. Pain level score was not documented. Objective findings (07-31-2015, 09-04-2015) revealed antalgic gait, lumbar tenderness with spasm, decreased lumbar range of motion, decreased sensation at the dorsum of the left foot and posterolateral aspect of the left calf, and decreased toe flexion and extension on the left. The injured worker is temporary total disability. The treatment plan included medication management. The treating physician prescribed Soma 350mg #60, Ibuprofen 800mg #90 and Restoril 15mg #30. Medical records indicate that the injured worker has been on Ibuprofen since 2014. The utilization review dated 09-24-2015, non-certified the request for Soma 350mg #60, Ibuprofen 800mg #90 and Restoril 15mg #30.

IMR ISSUES, DECISIONS AND RATIONALES

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

Soma 350mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Carisoprodol (Soma).

MAXIMUS guideline: Decision based on MTUS General Approaches 2004, Section(s): Initial Approaches to Treatment, and Chronic Pain Medical Treatment 2009, Section(s): Carisoprodol (Soma), Muscle relaxants (for pain), Weaning of Medications.

Decision rationale: Carisoprodol is a centrally acting skeletal muscle relaxant. This class of medications can be helpful in reducing pain and muscle tension thus increasing patient mobility. Muscle relaxants as a group, however, are recommended for short-term use only as their efficacy appears to diminish over time. In fact, Carisoprodol is not recommended by the MTUS for use to treat pain as it is metabolized to meprobamate, a barbiturate and a schedule-IV controlled substance. If this medication is used, it is only indicated for short-term use. There is no documentation this patient has ongoing muscle spasms, therefore, there is no indication for use of this medication. Medical necessity has not been established.

Ibuprofen 800mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Anti-inflammatory medications.

MAXIMUS guideline: Decision based on MTUS General Approaches 2004, Section(s): Initial Approaches to Treatment, and Low Back Complaints 2004, Section(s): Initial Care, Summary, and Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steroidal anti-inflammatory drugs), NSAIDs, GI symptoms & cardiovascular risk, NSAIDs, hypertension and renal function, NSAIDs, specific drug list & adverse effects.

Decision rationale: Ibuprofen (Motrin) is a non-steroidal anti-inflammatory medication (NSAID). It is recommended to treat mild to moderate pain. It is available over-the-counter as 200 mg tablets and by prescription as 400 mg and 800 mg tablets. The MTUS notes that doses over 400 mg do not provide greater pain relief. NSAIDs as a group are recommended for treatment of osteoarthritis and for short-term use in treating symptomatic pain from joint or muscle injury. In fact, MTUS guidelines notes that studies have shown use of NSAIDs for more than a few weeks can retard or impair bone, muscle, and connective tissue healing and perhaps even cause hypertension. This patient has had stable chronic pain for over 12 weeks and thus can be considered past the point where NSAIDs should be of value in treatment unless used short-term for exacerbation of the patient's chronic injuries. As the records do not show instructions to the patient for use of this medication only for exacerbations it is not indicated for use at this time.

Restoril 15mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Benzodiazepines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Benzodiazepines. Decision based on Non-MTUS Citation 1) Schutte-Rodin S, et al. Clinical Guideline for the Evaluation and Management of Chronic Insomnia in Adults. J Clin Sleep Med 2008;4(5):487-5042) American Psychiatric Association Practice Guideline for the Treatment of Patients With Major Depressive Disorder, Third Edition, originally published in October 2010.

Decision rationale: Temazepam (Restoril) is an intermediate-acting hypnotic of the benzodiazepine class of psychoactive medication. It is indicated for short-term (usually about two to six weeks) treatment of insomnia. It is very effective in initiating sleep but has the drawback of causing abnormal sleep patterns. Insomnia is defined by the American Academy of Sleep Medicine (AASM) as the subjective perception of difficulty with sleep initiation, duration, consolidation, or quality that occurs despite adequate opportunity for sleep, and that results in some form of daytime impairment. It is the most prevalent sleep disorder in the general population. It requires a full work-up to understand its etiology and to direct therapy. The AASM guideline recommends any pharmacologic treatment for chronic insomnia be accompanied by cognitive and behavioral treatments. Additionally, it recommends use of benzodiazepines or GABA receptor agonist medications be used short term followed by other sedating agents such as sedating antidepressants and atypical antipsychotics. The American Psychiatric Association guidelines note less evidence available to support treating insomnia in a depressed patient with a selective GABA agonist. This patient has been experiencing sleep difficulties for over six months but there is no documentation of associated symptoms, such as daytime sleepiness, to corroborate that she is getting inadequate sleep. The sleep problem has been attributed to a secondary effect of her industrial injury but a full evaluation for the etiology of her insomnia has not been done. She is not receiving any cognitive or behavioral treatments. Use of this medication for her chronic sleeping problem does not meet the above guideline criteria. Medical necessity has not been established.