

<b>Case Number:</b>	CM15-0206338		
<b>Date Assigned:</b>	10/23/2015	<b>Date of Injury:</b>	04/09/1996
<b>Decision Date:</b>	12/04/2015	<b>UR Denial Date:</b>	10/14/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/20/2015

### 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: 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:

This is a 48 year old female who sustained a work-related injury on 4-9-96. Medical record documentation on 10-1-15 revealed the injured worker was being treated for reflex sympathetic dystrophy, fibromyalgia, and chronic pain. She reported constant right lower extremity pain. She rated her pain a 6 on a 10-point scale at best (no change from 9-17-15) and a 9 on a 10-point scale at worst (no change from 9-17-15). Her medication regimen included Intrathecal infusion, Soma 350 mg (since at least 6-4-15), Dilaudid 8mg (since at least 6-4-15) and Imitrex 25 mg. Objective findings included diffuse tenderness over the L5-S1 with forward flexion to 110 degrees and hyperextension to 10 degrees. She had bilateral sciatic notch tenderness and hyperesthesia to the distal left lower extremity. A request for Soma 350 mg #90, Dilaudid 8 mg #480, and a Thoracic CT Scan was received on 10-9-15. On 10-14-15, the Utilization Review physician determined Soma 350 mg #90, Dilaudid 8 mg #480, and a Thoracic CT Scan was not medically necessary.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Soma 350mg QTY: 90: Upheld**

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

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

**Decision rationale:** Per MTUS Chronic Pain Guidelines on muscle relaxant, Soma is not recommended for mild to moderate chronic persistent pain problems including chronic pain (other than for acute exacerbations) due to the high prevalence of adverse effects in the context of insufficient evidence of benefit as compared to other medications. Guidelines do not recommend long-term use of this muscle relaxant for this chronic 1996 injury. Additionally, the efficacy in clinical trials has been inconsistent and most studies are small and of short duration. These medications may be useful for chronic musculoskeletal pain, but there are no long-term studies of their effectiveness or safety. Submitted reports have not adequately demonstrated the indication or medical need for this treatment and there is no report of progressive deterioration in clinical findings, acute flare-up or new injury to support for its long-term use. There is no report of functional improvement resulting from its previous treatment to support further use as the patient remains unchanged. The Soma 350mg QTY: 90 is not medically necessary and appropriate.

**Dilaudid 8mg QTY: 480:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Intrathecal drug delivery systems, medications, Opioids (Classification).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use, Opioids, cancer pain vs. nonmalignant pain, Opioids, long-term assessment, Opioids, pain treatment agreement.

**Decision rationale:** Review indicates prescription of greater than 512 MED not including the intrathecal opiate dose, exceeding guidelines recommendation for less than the daily morphine equivalent dosing of 120 without demonstrated functional improvement from chronic treatment rendered. The MTUS provides requirements of the treating physician to assess and document for functional improvement with treatment intervention and maintenance of function that would otherwise deteriorate if not supported. It cites opioid use in the setting of chronic, non-malignant, or neuropathic pain is controversial. Patients on opioids should be routinely monitored for signs of impairment and use of opioids in patients with chronic pain should be reserved for those with improved functional outcomes attributable to their use, in the context of an overall approach to pain management that also includes non-opioid analgesics, adjuvant therapies, psychological support, and active treatments (e.g., exercise). Submitted documents show no evidence that the treating physician is prescribing opioids in accordance to change in pain relief, functional goals with demonstrated specific improvement in daily activities or decreased in medical utilization. There is no evidence presented of random drug testing results or utilization of pain contract to adequately monitor for narcotic safety, efficacy, and compliance. Additionally, there is no demonstrated evidence of specific increased functional status derived from the continuing use of opioids in terms of decreased pharmacological dosing of opioid

and use of overall medication profile with persistent severe pain for this chronic 1996 injury without acute flare, new injury, or progressive neurological deterioration. The Dilaudid 8mg QTY: 480 is not medically necessary and appropriate.

**Thoracic CT Scan QTY: 1:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper Back, CT Scan.

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies.

**Decision rationale:** Treatment Guidelines states Criteria for ordering imaging studies include Emergence of a red flag; Physiologic evidence of tissue insult or neurologic dysfunction; Failure to progress in a strengthening program intended to avoid surgery; Clarification of the anatomy prior to an invasive procedure, none identified here. Physiologic evidence may be in the form of definitive neurologic findings on physical examination and electrodiagnostic studies. Unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging studies if symptoms persist; however, review of submitted medical reports have not adequately demonstrated the indication for this MRI nor document any failed conservative trial with medications and therapy. The patient has chronic symptom complaints with diffuse non-correlating neurological findings without specific deficits or progressive deterioration for this chronic 1996 injury. When the neurologic examination is less clear, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. The Thoracic CT Scan QTY: 1 is not medically necessary and appropriate.