

Case Number:	CM15-0026864		
Date Assigned:	02/19/2015	Date of Injury:	03/11/2002
Decision Date:	04/06/2015	UR Denial Date:	01/24/2015
Priority:	Standard	Application Received:	02/12/2015

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:

The injured worker is a 45 year old female, who sustained an industrial injury on September 13, 2012. She has reported bilateral wrist pain, bilateral shoulder pain, depression and anxiety. The diagnoses have included chronic pain syndrome, reflexive sympathetic dystrophy, carpal tunnel syndrome, and adhesive capsulitis of the shoulder. Treatment to date has included medications, physical therapy, carpal tunnel surgery, cervical spine sympathetic block, acupuncture, cognitive behavioral therapy, and stellate ganglion block. A progress note dated January 9, 2015 indicates a chief complaint of left arm pain, left shoulder pain with decreased range of motion, color and temperature changes, swelling and sweating, right shoulder decreased range of motion, sleep difficulties, depression, and anxiety. Physical examination showed decreased range of motion of the bilateral shoulders, left wrist decreased range of motion, and no swelling of the hands or wrists. The treating physician is requesting a prescription for Terazocin. On January 22, 2015 Utilization Review denied the request citing non- California Medical Treatment Utilization Schedule American College of Occupational and Environmental Medicine Guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

One prescription of Soma 350 mg # 60 with 3 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 63-66.

Decision rationale: The patient was injured on 03/11/2002 and presents with mild to moderate back pain which radiates to both legs. The request is for SOMA 350 mg #60 with 3 refills. The RFA is dated 01/15/2015, and the patient is currently disabled. The patient has been taking this medication as early as 07/01/2014. MTUS Guidelines pages 63-66, "Carisoprodol (Soma): Neither of these formulations is recommended for longer than a 2 to 3-week period." This has been noted for sedated and relaxant effects. Upon physical examination, the patient has a decreased range of motion of the bilateral shoulders, decreased range of motion of the left wrist, paraspinal spasm, abnormal sensory exam, and a trigger point at L5. The patient is diagnosed with sciatica, HTN, IBS GI surgery (2005), and lumbar fusion L4-L5 (2008). MTUS recommends the requested Soma only for a short period of time. Soma has been prescribed since 07/01/2014. This exceeds the 2- to 3-week period recommended by MTUS Guidelines. Therefore, the requested Soma IS NOT medically necessary.

One prescription of Tylenol w/codeine # 3, 300-30 mg, #60 with 3 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for Use of Opioids Page(s): 76-78, 88-89.

Decision rationale: The request is for 1 prescription of Tylenol with Codeine #3, 300-30 mg, #60 with 3 refills. The patient has been taking Tylenol with codeine as early as 07/01/2014. MTUS Guidelines pages 88 and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4A's (analgesia, ADLs, adverse side effects, and adverse behavior) as well as pain assessment or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work, and duration of pain relief. On the 07/01/2014, 07/29/2014, 10/07/2014, 11/07/2014., 12/06/2014, and 12/08/2014 reports, the patient rates his pain as a 6/10 to 7/10. "Meds do help some." The patient continues to rate his pain the same from July to December with his medications. Although the treater provides pain scales, there does not appear to be any change in the patient's pain and function. There are no examples of ADLs which demonstrate medication efficacy, nor are there any discussions provided on adverse behavior/side effects. There are no pain management issues discussed such as CURES report, pain contract, etc. No outcome measures are provided either as required by MTUS Guidelines. Review of the reports does not provide any urine drug screen to show the patient's compliance with his medications. The treating physician does not provide proper documentation that is required by MTUS Guidelines for continued opiate use. Therefore, the requested Tylenol with codeine IS NOT medically necessary.

