

Case Number:	CM15-0042388		
Date Assigned:	03/12/2015	Date of Injury:	07/14/2005
Decision Date:	04/22/2015	UR Denial Date:	03/05/2015
Priority:	Standard	Application Received:	03/06/2015

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, Hawaii

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 61 year old female, who sustained an industrial injury on 7/14/2005. She reported pain to bilateral shoulders/upper extremities due to industrial injury. The injured worker was diagnosed as having anxiety state; depressive disorder; adhesive capsulitis of shoulder; synovitis/tenosynovitis hand/wrist. Treatment to date has included acupuncture; physical therapy; medications. Currently, the injured worker complains of pain in the bilateral upper extremities with the right greater than the left. The injured worker is indicating home exercise program to stay active and relates that pain is never totally eliminated but medications allow for sleep (not on right shoulder) and improving activities of daily living.

IMR ISSUES, DECISIONS AND RATIONALES

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

Carisoprodal 350mg quantity: 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines muscle relaxants. Decision based on Non-MTUS Citation Official Disability Guidelines- Treatment in Workers' Compensation (ODG-TWC) Pain Procedure Summary.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodal (Soma); Muscle relaxants (for pain) Page(s): 29, 63-66.

Decision rationale: The patient presents with pain in the upper extremities, right greater than left. The current request is for Carisoprodal 350 mg, quantity: 60. The treating physician states that her pain inhibits her from performing ADLs and sleeping through the night. The MTUS guidelines are very clear regarding Soma which states, "Not recommended. This medication is not indicated for long-term use." Continued usage of this muscle relaxant is not supported by MTUS beyond two to three weeks. The patient has been prescribed this medication for several months. In this case, the treating physician has not provided documentation as to the patient having muscle spasms. There has been no compelling rationale provided by the treating physician to continue this patient on this centrally acting skeletal muscle relaxant beyond the MTUS guideline recommendation of two to three weeks. The current request is not medically necessary and the recommendation is for denial.

Trazadone HCL 50mg quantity: 30: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines anti-depressants.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, antidepressants for chronic pain.

Decision rationale: The patient presents with pain in the upper extremities, right greater than left. The current request is for Trazodone HCL 50 mg, quantity: 30. The treating physician states that her pain inhibits her from performing ADLs and sleeping through the night. The ODG guidelines state, "Recommended as an option for insomnia, only for patients with potentially coexisting mild psychiatric symptoms such as depression or anxiety. See also Insomnia treatment, where it says there is limited evidence to support its use for insomnia, but it may be an option in patients with coexisting depression." In this case, the treating physician has documented that the patient has depressive disorder. The guidelines do support the use of Trazodone for insomnia when the patient also is diagnosed with depression. The current request is medically necessary and the recommendation is for authorization.