MAXIMUS Federal Services

Case Number:	CM15-0086696		
Date Assigned:	06/16/2015	Date of Injury:	05/28/2008
Decision Date:	07/17/2015	UR Denial Date:	04/13/2015
Priority:	Standard	Application Received:	05/05/2015

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, Texas, Florida
Certification(s)/Specialty: Anesthesiology, Pain Management, Hospice & Palliative 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 62 year old female, who sustained an industrial injury on May 28, 2008, incurring low back injuries. She was diagnosed with cervical spine disc disease and herniation, thoracic spine disc bulge, lumbar spine disc disease with herniation and right shoulder impingement syndrome. Treatment included pain medications, muscle relaxants, anti-inflammatory drugs, sleep aides and work restrictions. She underwent right shoulder arthroscopy. Currently, the injured worker complained of persistent, chronic low back pain, upper back pain, neck pain and right shoulder pain. She also complained of decreased sensation in the right calf and ankle. The treatment plan that was requested for authorization included prescriptions for Fioricet, Ambien, and Soma.

IMR ISSUES, DECISIONS AND RATIONALES

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

60 tablets Fioricet (with two refills): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 23 of 127.

Decision rationale: Regarding the request for Fioricet, Chronic Pain Medical Treatment Guidelines state that barbiturate containing analgesic agents is not recommended for chronic pain. They go on to state that the potential for drug dependence is high and no evidence exists to show a clinically important enhancement of analgesic efficacy of BCAs due to the barbiturate constituents. As such, the currently requested Fioricet is not medically necessary.

30 Ambien 10mg (with two refills): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain (Chronic).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain, Sleep Medication, Insomnia treatment.

Decision rationale: Regarding the request for Ambien, California MTUS guidelines are silent regarding the use of sedative hypnotic agents. ODG recommends the short-term use (usually two to six weeks) of pharmacological agents only after careful evaluation of potential causes of sleep disturbance. They go on to state the failure of sleep disturbances to resolve in 7 to 10 days, may indicate a psychiatric or medical illness. Within the documentation available for review, there are no subjective complaints of insomnia, no discussion regarding how frequently the insomnia complaints occur or how long they have been occurring, no statement indicating what behavioral treatments have been attempted for the condition of insomnia, and no statement indicating how the patient has responded to Ambien treatment. Finally, there is no indication that Ambien is being used for short-term use as recommended by guidelines. In the absence of such documentation, the currently requested Ambien is not medically necessary.

30 tablets Soma 350mg (with two refills): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol (Soma).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63-66 of 127.

Decision rationale: Regarding the request for carisoprodol (Soma), Chronic Pain Medical Treatment Guidelines support the use of non-sedating muscle relaxants to be used with caution as a 2nd line option for the short-term treatment of acute exacerbations of pain. Guidelines go on to state that Soma specifically is not recommended for more than 2 to 3 weeks. Within the documentation available for review, there is no identification of a specific analgesic benefit or objective functional improvement as a result of the carisoprodol. Additionally, it does not appear that this medication is being prescribed for the short-term treatment of an acute exacerbation, as recommended by guidelines. In the absence of such documentation, the currently requested carisoprodol (Soma) is not medically necessary.