

Case Number:	CM14-0123361		
Date Assigned:	08/08/2014	Date of Injury:	02/08/2008
Decision Date:	10/14/2014	UR Denial Date:	07/02/2014
Priority:	Standard	Application Received:	08/04/2014

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. The expert reviewer is Board Certified in Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in Florida. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 50 year old male with a reported date of injury on 02/08/2008. The mechanism of injury was a fall. The diagnoses included lumbar myelopathy and thoracic or lumbosacral neuritis. The past treatments included pain medication, acupuncture, and epidural steroid injections. There were no diagnostic imaging studies provided for review. There was no surgical history noted in the records. The subjective complaints on 06/26/2014 included pain to the right lower extremity. The physical examination noted reduced spasms and tenderness in the paravertebral musculature of the spine when compared to previous visit. Decreased sensation was noted over the right L5 dermatome with pain. The medications included soma and Voltaren gel. A request was received for Carisoprodol tab 350mg day supply: 30 quantity 60 with 2 refills, and Voltaren gel 1%, day supply: 7, quantity 100 with 2 refills. The rationale was to relieve pain. The request for authorization form was not provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

Carisoprodol tab 350mg day supply:30 quantity 60 with 2 refills: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol (Soma), Page(s): 29.

Decision rationale: The request for Carisoprodol tab 350mg day supply:30 quantity 60 with 2 refills is not medically necessary. The California MTUS Guidelines state carisoprodol is not indicated for long-term use and is not recommend to treat chronic pain. The patient has chronic low back pain. As carisoprodol is not recommended by the guidelines the request is not supported. As such, the request is not medically necessary.

Voltaren gel 1%, day supply:7, quantity 100 with 2 refills: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 112.

Decision rationale: The request for Voltaren gel 1%, day supply:7, quantity 100 with 2 refills is not medically necessary. The California MTUS guidelines state that Voltaren gel is indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment. It has not been evaluated for treatment of the spine, hip or shoulder. The injured worker has chronic back pain. The notes indicate that Voltaren gel is to be applied twice a day to the lumbar spine. As Voltaren gel is not indicated for the spine the request is not supported by the guidelines. As such, the request is not medically necessary.