

Case Number:	CM14-0129412		
Date Assigned:	08/18/2014	Date of Injury:	03/31/1998
Decision Date:	10/08/2014	UR Denial Date:	07/17/2014
Priority:	Standard	Application Received:	08/13/2014

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, 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 68 year old male who reported an injury on 03/31/1998; the mechanism of injury was not provided. Diagnoses included lumbar spine pain and degenerative disc disease of the lumbar spine. Past treatments included a TENS unit, back brace, and medications. Past diagnostics included an x-ray of the lumbar spine, and an MRI of the lumbar spine dated 01/24/2014, which indicated disc protrusion and central stenosis at L3-4, and disc protrusion with facet arthropathy at L5-S1. Past surgical history included laminectomy and discectomy in 1996, and a lumbar fusion in 1998. The clinical note dated 07/08/2014 indicated the injured worker complained of back pain with spasms, at times rated 10/10, and difficulty sleeping due to pain. Physical exam indicated 40 percent flexion and 20 percent extension, with normal motor and neurological exams. Current medications included Soma 250 mg, and Norco 10/325 mg. The treatment plan included Soma 250 mg #18 and Norco 10/325 mg #144 with 1 refill; the rationale for treatment was not provided. The request for authorization form was completed on 08/04/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Soma 250mg #18: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Soma (carisoprodol); Muscle relaxants (for pain); Weaning of Medi. Decision based on Non-MTUS Citation Arkansas Medicaid Pharmacy Program. Tapering schedule developed by the

Department of Veterans Affairs Medical Center, Portland, Oregon. Oregon DUR Board Newsletter. 20002;4:1 28 Dec. 2005

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

Decision rationale: The request for Soma 250 mg #18 is not recommended. The California MTUS guidelines indicate that carisoprodol (Soma) is not recommended and is not indicated for long-term use. The injured worker complained of back pain with spasms, at times rated 10/10, and difficulty sleeping due to pain. The injured worker had been taking the requested medication since at least 12/09/2013. The continued use of the medication would exceed the guideline recommendation for a short course of treatment. There is a lack of clinical documentation to indicate the need for Soma beyond the guideline recommendations. There is a lack of documentation indicating the injured worker has significant objective functional improvement with the medication. Additionally, the request does not include indicators of frequency for taking the medication. Therefore the request for Soma 250 mg #18 is not recommended.

Norco 10/325mg #144 with 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use; Weaning of Medications.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use Page(s): 74 & 78.

Decision rationale: The request for Norco 10/325 mg #144 with 1 refill is not medically necessary. The California MTUS Guidelines state that criteria for the ongoing management of opioid use include ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The guidelines state that the pain assessment should include current pain, the least reported pain over the period since the last assessment, average pain, intensity of pain after taking the opioid, how long it takes for pain relief, and long pain relief lasts. Documentation should also include side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non-adherent) drug-related behaviors. The injured worker complained of back pain with spasms, at times rated 10/10, and difficulty sleeping due to pain. The injured worker had been taking the requested medication since at least 12/09/2013. There is a lack of quantified evidence of pain relief, functional improvement, and the occurrence of any aberrant drug-related behaviors through the use of urine drug screens. Additionally, the request does not include indicators of frequency for taking the medication. Therefore the request for Norco 10/325 mg #144 with 1 refill is not medically necessary.