

Case Number:	CM14-0139340		
Date Assigned:	09/05/2014	Date of Injury:	02/01/2004
Decision Date:	10/10/2014	UR Denial Date:	08/13/2014
Priority:	Standard	Application Received:	08/28/2014

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 Physical Medicine & Rehabilitation, and is licensed to practice in California. 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 female who reported an injury on 02/01/2004 due to an unknown mechanism. Diagnoses were disc disorder, lumbar, and lumbar radiculopathy. Past treatments were transforaminal epidural steroid injection on 08/13/2014. Diagnostic studies were noted as an MRI on 09/14/2009. Surgical history was not reported. Physical examination on 08/15/2014 revealed pain was rated a 4 on a scale of 1 to 10 with medications. Without medications, pain was rated an 8 on a scale of 1 to 10. The injured worker reported greater than 60% pain relief in the lower extremities since having the transforaminal epidural steroid injection. She also reported sleeping better since the leg pain decreased. It was also reported that the injured worker was not trying any other therapies for pain relief. Neurological examination for motor testing was limited by pain. Sensory examination for light touch sensation was decreased over lateral foot, lateral calf, lateral thigh on the left side, and sensation to pinprick was decreased over lateral foot, medial foot, medial calf, and lateral calf on the right side. Medications were Flexeril, Soma, Senokot, Lidoderm, Neurontin, Percocet, Metformin, prednisone, Qvar, Lisinopril, Advair, Ambien, Glipizide, ipratropium bromide powder, Maxzide, ranitidine, Senna laxative, Singulair, theophylline, and Ventolin HFA inhaler. The injured worker reported that she returned to work full time. The treatment plan was to continue medications as directed and to hold off on the physical therapy for right now. The rationale was not submitted. The Request for Authorization was submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Percocet 10/325mg #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Guidelines Percoce Ongoing Management, Page(s): 75, 86.

Decision rationale: The request for Percocet 10/325 mg #120 is not medically necessary. The California Medical Treatment Utilization Schedule Guidelines recommend Oxycodone/Acetaminophen (Percocet) for moderate to severe chronic pain and that there should be documentation of the 4 A's for ongoing monitoring, including analgesia, activities of daily living, adverse side effects, and aberrant drug taking behavior. It further recommends that dosing of opioids not exceed 120 mL oral morphine equivalents per day. The injured worker recently had a transforaminal Epidural Steroid Injection with no reduction in the medications. The request for Percocet does not indicate a frequency for the medication. Therefore, the request for Percocet 10/325 mg #120 is not medically necessary.

Soma 350mg #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol, Page(s): 29, 65.

Decision rationale: The request for Soma 350 mg #30 is not medically necessary. The California Medical Treatment Utilization Schedule states that Soma (Carisoprodol) is not indicated for longer than a 2 to 3 week period. Carisoprodol is a commonly prescribed, centrally acting skeletal muscle relaxant. It has been suggested that the main effect is due to generalized sedation and treatment of anxiety. Abuse has been noted for sedative and relaxant effects. Carisoprodol abuse has also been noted in order to augment or alter effects of other drugs. A withdrawal syndrome has been documented that consists of insomnia, vomiting, tremors, muscles twitching, anxiety, and ataxia when abrupt discontinuation of large doses occurs. Tapering should be individualized for each patient. The clinical documentation submitted for review does provide evidence that the injured worker has been on this medication for an extended duration of time. Also, the request does not indicate a frequency for the medication. Therefore, the request for Soma 350 mg #30 is not medically necessary.

Ambien CR 12.5mg #30: 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 (ODG) Pain, Zolpidem

Decision rationale: The request for Ambien CR 12.5 mg #30 is not medically necessary. The Official Disability Guidelines indicate that Zolpidem (Ambien) is appropriate for the short term treatment of insomnia, generally 2 to 6 weeks. The clinical documentation submitted for review does provide evidence that the injured worker has been on this medication for an extended duration of time. Also, the request does not indicate a frequency for the medication. Therefore, the request for Ambien CR 12.5 mg #30 is not medically necessary.

Neurotin 800mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Epilepsy Drug.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin, Page(s): 16.

Decision rationale: The request for Neurontin 800 mg #120 is not medically necessary. The California Medical Treatment Utilization Schedule Guidelines indicate that gabapentin is shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first line treatment for neuropathic pain. The efficacy of this medication was not reported. Also, the request does not indicate a frequency for the medication. Therefore, the request for Neurontin 800 mg #120 is not medically necessary.