MAXIMUS Federal Services

Case Number:	CM14-0143437		
Date Assigned:	09/10/2014	Date of Injury:	04/23/2004
Decision Date:	10/14/2014	UR Denial Date:	08/06/2014
Priority:	Standard	Application Received:	09/04/2014

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 Physical Medicine and Rehabilitation and is licensed to practice in California and Washington. 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 56-year-old female who reported an injury on 04/23/2004 due to an unknown mechanism. Diagnoses were cervical strain with intermittent symptoms of left cervical radiculopathy; bilateral shoulder impingement, left side greater than right with magnetic resonance imaging (MRI) abnormalities; status post corticosteroid injection in the left shoulder; thoracic strain; lumbar strain with left lumbar radiculitis with abnormal MRI of the lumbar spine and abnormal Electromyogram (EMG) and Nerve Conduction studies with left L5 radiculopathy. Physical examination on 07/08/2014 revealed a history of cervical spine, lumbar spine, bilateral shoulder, and bilateral wrist pain that the injured worker described as a 10/10 when not on medications. The medication helped to decrease it to a 6/10. Examination revealed Spurling sign was positive to the left causing left scapular pain. There was mild paralumbar muscle spasm noted, left greater than right. There was minimal spasm and tenderness noted in the T7-11 region bilaterally. Medications were morphine sulfate 15 mg, Norco, Soma 350 mg, Ambien 10 mg, Naproxen sodium 550 mg, Prilosec/omeprazole 20 mg, Lidoderm patches. The rationale and Request for Authorization were not submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Morphine Sulfate 15mg # 30: 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 Ongoing Management Page(s): 78.

Decision rationale: The decision for morphine sulfate 15 mg quantity 30 is not medically necessary. The California Medical Treatment Utilization Schedule Guidelines state that for ongoing management of opioids, there should be documentation of the 4 A's, including analgesia, activities of daily living, adverse side effects, and aberrant drug taking behavior. The efficacy of this medication was not reported. The request does not indicate a frequency for the medication. There were no significant factors reported to justify the use of this medication. Therefore, this request is not medically necessary.

Soma 350mg (unspecified quantity): Upheld

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

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

Decision rationale: The decision for Soma 350 mg (quantity unspecified) 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 insomnia, vomiting, tremors, muscle twitching, anxiety, and ataxia when abrupt discontinuation of large doses occurs. Tapering should be individualized for each patient. The efficacy of this medication was not reported. The request does not indicate a frequency for the medication. There were no significant factors reported to justify the continued use of this medication. Also, the guidelines state that this medication should be used no longer than a 2 to 3 week period. Therefore, this request is not medically necessary.

Ambien 10mg (unspecified quantity): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines

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

Decision rationale: Decision for Ambien 10 mg (unspecified quantity) is not medically necessary. The Official Disability Guidelines state that zolpidem is a prescription short acting nonbenzodiazepine hypnotic which is approved for short term, usually 2 to 6 weeks, treatment of insomnia. Zolpidem is in the same drug class as Ambien. Proper sleep hygiene is critical to the

individual with chronic pain and often is hard to obtain. Various medications may provide short term benefit. Most sleeping pills, so called minor tranquilizers and antianxiety agents, are commonly prescribed in chronic pain. They can be habit forming and they impair function and memory more than opioid pain relievers. There is also concern that they may increase pain and depression over the long term. Cognitive behavior therapy (CBT) should be an important part of an insomnia treatment plan. The efficacy was not reported for this medication. The request does not indicate a frequency for the medication or a quantity. Therefore, the request is not medically necessary.

Naproxen sodium 550mg: 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 Chronic Pain, Naproxen, Page(s): 72,73.

Decision rationale: The decision for naproxen sodium 550 mg is not medically necessary. The California Medical Treatment Utilization Schedule Guidelines indicate that Naproxen is a non-steroidal anti-inflammatory drug (NSAID) for the relief of the signs and symptoms of osteoarthritis and they recommend the lowest effective dose be used for all NSAIDs for the shortest duration of time consistent with the individual patient treatment goals. The efficacy of this medication was not reported. The request does not indicate a frequency for the medication, nor does it indicate a quantity. Therefore, this request is not medically necessary.