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| Case Number: | CM14-0144607 | | |
| Date Assigned: | 09/12/2014 | Date of Injury: | 06/04/1992 |
| Decision Date: | 10/15/2014 | UR Denial Date: | 08/25/2014 |
| Priority: | Standard | Application Received: | 09/05/2014 |

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 Internal Medicine, 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 45-year-old male who reported an injury on 06/04/1992 due to an unknown mechanism. The physical examination on 09/04/2014 revealed complaints of bilateral low back pain that radiated into the left buttocks, left posterior thigh, and left posterior calf. It was reported that prolonged sitting and standing, lifting, twisting, driving, and coughing were exacerbating factors. Past surgical history was multiple lumbar spine surgeries, including fusion. The injured worker does work full time. The examination revealed lumbar range of motion was restricted in all directions. Lumbar discogenic provocative maneuvers were positive. Diagnoses were left L5-S1 radiculopathy with left lower extremity weakness, failed back surgery syndrome, lumbar postlaminectomy syndrome, lumbar disc protrusion, lumbar stenosis, and lumbar sprain/strain. The rationale stated that "Soma meets the MTUS and ODG Guidelines as it provides 90% decrease of the patient's spasms with 90% improvement in the patient's activities of daily living such as self care and dressing. The medication also provides the patient with an additional 4 hours of sleep per night. Without this medication, the patient suffers from daily painful spasms which wake him up from sleep and he can only get at the most 2 hours of uninterrupted sleep at the time." The Request for Authorization was not submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Methadone 10mg 5 tabs every 8 hours prn #450 with 0 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Food and Drug Administration (FDA)

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

Decision rationale: The decision for Methadone 10mg 5 tabs every 8 hours prn #450 with 0 refills is not medically necessary. The Official Disability Guidelines have set up steps for prescribing methadone. The drug should be used with caution in opioid naive patients due to the risk of life threatening hypoventilation. Inform the patient that they should not be tempted to take more methadone than prescribed due to the dangerous build up that can lead to death. The patient should be warned not to use alcohol, benzodiazepines, or other CNS depressants. Inform the patient of the potential adverse side effects of the methadone. Although the injured worker has reported pain relief and functional improvement from the medication, the provider did not indicate a frequency for the medication. Therefore, this request is not medically necessary.

Soma 350mg qid #60 with 1 refill: 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, Carisoprodol Page(s): 29,65.

Decision rationale: The decision for Soma 350mg qid #60 with 1 refill is not medically necessary. The California Medical Treatment Utilization Schedule states that Soma (carisoprodol) is not indicated for longer than a 2 week 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, muscle 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 longer than a 2 week to 3 week period. Also, the request does not indicate a frequency for the medication. Therefore, this request is not medically necessary.