

Case Number:	CM14-0148411		
Date Assigned:	09/18/2014	Date of Injury:	11/16/1978
Decision Date:	10/17/2014	UR Denial Date:	08/14/2014
Priority:	Standard	Application Received:	09/12/2014

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 Management 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:

According to the records made available for review, this is a 71-year-old male with an 11/16/78 date of injury. At the time (8/7/14) of request for authorization for Carisoprodol 350mg #90, Lorazepam 1mg #15 (X1 refill), and Percocet 10/325mg #180, there is documentation of subjective (left shoulder, neck and low back pain; severe muscle spasms in right thoracic region; and unable to sleep) and objective (limited range of motion to bilateral shoulder; tenderness to palpation over anterior right shoulder, lateral hips, and thoracic/lumbar region; and severe spasm along the right lateral border between T2-8 region) findings, current diagnoses (chronic pain syndrome, chronic low back pain, degenerative T12-S1 disc, L3-4 and L4-5 spinal stenosis, severe right thoracic spasm, and left shoulder degenerative joint disease), and treatment to date (epidural steroid injection, heat, ice, stretching exercise, and medications (including ongoing treatment with Percocet, Senna, and Voltaren gel)). Medical report identifies a request for temporary prescription for Soma. Regarding Carisoprodol, there is no documentation of acute exacerbations of chronic low back pain, intention to treat over a short course (less than two weeks), and Carisoprodol used as a second line option. Regarding Percocet, there is no documentation that prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects; and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as result of Percocet use to date.

IMR ISSUES, DECISIONS AND RATIONALES

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

Carisoprodol 350mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 29. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG)

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

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies that Carisoprodol (Soma) is not recommended and that this medication is not indicated for long term use. ODG identifies that muscle relaxants are recommended as a second line option for short-term (less than two weeks) treatment of acute low back pain and for short-term treatment of acute exacerbations in patients with chronic low back pain. Within the medical information available for review, there is documentation of diagnoses of chronic pain syndrome, chronic low back pain, degenerative T12-S1 disc, L3-4 and L4-5 spinal stenosis, severe right thoracic spasm, and left shoulder degenerative joint disease. However, despite documentation of severe muscle spasms and given documentation of an 11/16/78 date of injury, there is no (clear) documentation of acute muscle spasms or acute exacerbations of chronic low back pain. In addition, despite documentation of records reflecting temporary prescriptions for Soma/Carisoprodol and given documentation of a request for Carisoprodol 350mg #90, there is no documentation of the intention to treat over a short course (less than two weeks). Furthermore, there is no documentation of Carisoprodol used as a second line option. Therefore, based on guidelines and a review of the evidence, the request for Carisoprodol 350mg #90 is not medically necessary.

Lorazepam 1MG #15 (X1 REFILL): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies that benzodiazepines are not recommended for long-term and that most guidelines limit use to 4 weeks. Within the medical information available for review, there is documentation of diagnoses of chronic pain syndrome, chronic low back pain, degenerative T12-S1 disc, L3-4 and L4-5 spinal stenosis, severe right thoracic spasm, and left shoulder degenerative joint disease. However, there is no documentation of the intention to treat over a short course. Therefore, based on guidelines and a review of the evidence, the request for Lorazepam 1mg #15 (X1 refill) is not medically necessary.

Percocet 10/325mg #180: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS Page(s): 74-80. Decision based on Non-MTUS Citation Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines necessitate documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects, as criteria necessary to support the medical necessity of opioids. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of chronic pain syndrome, chronic low back pain, degenerative T12-S1 disc, L3-4 and L4-5 spinal stenosis, severe right thoracic spasm, and left shoulder degenerative joint disease. In addition, there is documentation of ongoing treatment with Percocet. However, there is no documentation that prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. In addition, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as result of Percocet use to date. Therefore, based on guidelines and a review of the evidence, the request for Percocet 10/325mg #180 is not medically necessary.