

Case Number:	CM14-0156366		
Date Assigned:	09/25/2014	Date of Injury:	04/25/1988
Decision Date:	10/29/2014	UR Denial Date:	09/12/2014
Priority:	Standard	Application Received:	09/24/2014

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 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 52-year-old male who reported an injury on 04/25/1988. The mechanism of injury was not included. The diagnosis included lumbar disc injury, lumbar facet arthralgia, bilateral sciatica, L5-S1 fusion, and bilateral radiculopathy. The past treatments included medications, steroid injections, radiofrequency ablations, spinal cord stimulator, physical therapy, chiropractic therapy, and prolotherapy. The progress note, dated 07/25/2014, noted the injured worker complained of pain flare, rated 8/10 to 9/10, to his right greater than left lower extremity. The physical examination revealed 5/5 strength in the bilateral lower extremities, intact sensation, right L3-4 tenderness and spasm, and tenderness over the bilateral L2-3, L3-4, L4-5, and L5-S1. The medications included Fentanyl 12 mcg; Percocet 5 mg, 3 times a day; and Soma 350 mg, twice a day. The treatment plan requested a radiofrequency ablation, refilled medications, gave samples of Flector patch, and a Toradol injection. The Request for Authorization form was not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Soma 350mg: 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 Carisoprodol (Soma) Page(s): 29.

Decision rationale: The request for Soma 350 mg is not medically necessary. The injured worker had a flare of pain to an unspecified site. The California MTUS Guidelines state Soma is not recommended, and not indicated for long term use, with risk of dependence and abuse. The injured worker had been prescribed Soma since as early as 02/13/2014. This exceeds the evidence based recommendation for short term use. There is no documentation of the efficacy of the medication. Additionally, the request did not include the frequency intended for use to determine medical necessity. Given the previous, the continued use of Soma is not supported at this time. As such, the request is not medically necessary.

Toradol 60mg #45: 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 Medical Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) Page(s).

Decision rationale: The request for Toradol 60 mg #45 is not medically necessary. The injured worker had a pain flare up to an unspecified site. An IM Toradol injection of 60 mg was given on 07/25/2014. The California MTUS Guidelines recommend nonsteroidal anti-inflammatory drugs for the treatment of osteoarthritis at the lowest dose for the shortest period in patients with moderate to severe pain. They are also recommended in the treatment of back pain with acute exacerbation as second line treatment after Tylenol and as a short term option for chronic low back pain. Specifically, Toradol is not indicated for minor or chronic painful conditions. Generally, Toradol should not exceed 40 mg per day dosing over a 5 day period. The rationale for the use and dose of Toradol is not provided. There is no indication of failure of first line medications. Additionally, the request does not indicate the frequency at which the medication is prescribed in order to determine the necessity of the medication. Given the previous, the use of Toradol is not indicated at this time. Therefore, the request is not medically necessary.