

Case Number:	CM14-0161297		
Date Assigned:	10/06/2014	Date of Injury:	01/06/2013
Decision Date:	11/06/2014	UR Denial Date:	09/17/2014
Priority:	Standard	Application Received:	10/01/2014

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 Illinois. 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 33-year-old male who reported injury on 01/06/2013. Mechanism of injury was not submitted for review. He has diagnoses of lumbosacral sprain/strain, L4-5 discopathy, and L5-S1 disc bulge with radicular involvement. Past medical treatment consists of physical therapy and medication therapy. Medications consist of Soma and topical analgesia. The injured worker has undergone an MRI and electro diagnostic studies of the lumbar spine. On 08/08/2014, the injured worker complained of lumbar spine pain. Physical examination noted that the injured worker rated his pain 6/10 to 7/10 with pain medication and 8/10 to 9/10 without. Examination of the lumbar spine revealed decreased range of motion, there was tenderness to the paraspinal muscles, right greater than left. Kemp's sign was positive bilaterally. Straight leg raise on the right was positive at 60 degrees to the posterior thigh and 70 degrees on the left to the posterior thigh. Sensation was decreased at 5/5 bilaterally at L4, L5, and S1. Strength was decreased 4/5 bilaterally at the L4, L5, and S1. Deep tendon reflexes were 1++ bilaterally in the patellar and Achilles tendon. The medical treatment plan is for the injured worker to continue the use of medication therapy. The rationale and Request for Authorization form were 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 (Carisoprodol) 350 mg, #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol (Soma) Page(s): 29, 65. Decision based on Non-MTUS Citation FDA (Carisoprodol); Section 9792.24.2

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

Decision rationale: The request for Soma (Carisoprodol) 350 mg, #120 is not medically necessary. The California MTUS state that 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, muscle twitching, anxiety, and ataxia when abrupt discontinuation of large doses occurs. Tapering should be individualized for each patient. The submitted documentation indicates that the injured worker has been on the medication since at least 08/2014, exceeding the recommended guidelines for a 2 to 3 week period. Additionally, the request as submitted is for Soma (Carisoprodol) 350 mg with a quantity of 120, also exceeding recommendations. Furthermore, the efficacy was not submitted for review, nor was there any evidence submitted indicating that the medication was helping with any functional deficits the injured worker had. Given the above, the injured worker is not within the MTUS recommended guidelines. As such, the request is not medically necessary.

Diclofenac/Lidocaine cream (3%-5%), 180g: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111, 112-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

Decision rationale: The request for diclofenac/lidocaine cream (3%-5), 180mg is not medically necessary. The California MTUS Guidelines state that transdermal compounds are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Topical analgesia is primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least 1 drug that is not recommended is not recommended. Topical NSAIDs are recommended for arthritis and tendonitis, in particular, that of the knee and elbow or joints that are amenable to topical treatment. Guidelines also state that Lidoderm patch is the only topical form of lidocaine approved. The submitted documentation did not indicate that the topical analgesia was helping with any functional deficits the injured worker might have had. Additionally, the efficacy of the medication was not submitted for review. Furthermore, the MTUS Guidelines do not recommend lidocaine as a topical other than a Lidoderm patch. The request as submitted did not indicate the frequency or duration of the medication. As such, the request is not medically necessary.

