

Case Number:	CM14-0057630		
Date Assigned:	02/11/2015	Date of Injury:	06/16/2004
Decision Date:	03/16/2015	UR Denial Date:	04/10/2014
Priority:	Standard	Application Received:	04/28/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California, Washington

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 58-year-old female who reported an injury on 06/16/2014. The mechanism of injury was not submitted for review. The injured worker has diagnoses of failed back syndrome, lumbar fibromyalgia/myositis, knee/lower leg pain, lumbar radiculopathy, degenerative disc disease of the shoulder, status post lumbar fusion. Past medical treatment consists of surgery, physical therapy, medication therapy. Medication include Fentanyl 25 mcg/hour transdermal patch, Lyrica 75 mg, naproxen 500 mg, Norco 10/325 mg, Prilosec 20 mg, Restoril 30 mg, Robaxin 750 mg, Soma 350 mg, Fentanyl 100 mcg/hour transdermal patch. On 12/11/2014, the injured worker underwent a urine drug screen which showed that results were consistent with prescription medications. On 02/03/2015, the injured worker complained of low back, right hip and feet pain. The injured worker stated that the medications helped. Physical examination of the lumbar spine revealed that there was tenderness to palpation at the lumbar facets at both sides at L3 to S1 region. There was pain noted over the lumbar intervertebral spaces on palpation. The injured worker's gait appeared to be normal. Anterior lumbar flexion caused pain. There was pain noted at lumbar extension. Neurological testing and motor strength were grossly normal. Medical treatment plan was for the injured worker to continue with 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:

Dilaudid 2mg #40: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ongoing management, Opioids, dosing Page(s): 60, 78, 86.

Decision rationale: The request for Dilaudid 2mg #40 is not medically necessary. The California MTUS Guidelines recommend opioids for chronic pain. There should be documentation of an objective improvement in function, objective decrease in pain, and evidence that the injured worker is being monitored for aberrant drug behaviors and side effects. The cumulative dosing of all opioids should not exceed 120 mg or a morphine equivalence per day. The submitted documentation did not indicate the efficacy of the medication, nor did it indicate that the Dilaudid was helping with any functional deficits the injured worker had. Additionally, there were no proper assessments submitted for review indicating what pain levels were before, during, and after medication administration. A UA was obtained on 12/11/2014 indicating that the injured worker was consistent with prescription medications. However, there was no evidence in the report of objective improvement in function, nor was there any evidence of decreased on medication. Given the above, the request would not be indicated. As such, the request is not medically necessary.

Restoril 30mg #40: Upheld

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

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

Decision rationale: The request for Restoril 30mg #40 is not medically necessary. The California MTUS Guidelines do not recommend the use of benzodiazepines (Restoril) as treatment for patients with chronic pain for longer than 4 weeks due to the high risk of psychological and physiological dependency. The clinical documentation submitted for review indicates that the injured worker has been on this medication for an extended duration of time. Additionally, the efficacy of the medication was not submitted for review to warrant the continuation of the medication. There were no other significant factors provided to justify the use outside of current guidelines. Given the above, the request would not be indicated. As such, the request is not medically necessary.

Robaxin 750mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for pain).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63.

Decision rationale: The request for Robaxin 750mg #120 is not medically necessary. The California MTUS Guidelines recommend muscle relaxants (Robaxin) as a second line option for short term treatment of acute low back pain and their use is recommended for less than 3 weeks. There should be documentation of objective functional improvement. The submitted documentation did not provide the efficacy of the medication, nor did it indicate that it was helping with any functional deficits the injured worker was having. There was also no indication of the injured worker being diagnosed with spasm or having any spasm on physical examination. Additionally, the submitted documentation indicates that the injured worker has been on the medication for an extended duration of time, exceeding recommended guidelines for short term use. Therefore, continued use of the medication would not be supported. As such, the request is not medically necessary.

Soma 350mg #120: Upheld

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

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

Decision rationale: The request for Soma 350mg #120 is not medically necessary. The California MTUS 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 of insomnia, vomiting, tremors, muscle twitching, anxiety, and ataxia when abrupt discontinuation of large doses occurs. The submitted documentation indicated that the injured worker has been on the medication for an extended duration of time, exceeding recommended guidelines for short term use. Therefore, continued use of the medication would not be supported. Additionally, the efficacy of the medication was submitted for review. There were no other significant factors provided to justify the use outside of current guidelines. As such, the request the request is not medically necessary.