

Case Number:	CM15-0005834		
Date Assigned:	02/17/2015	Date of Injury:	09/16/2002
Decision Date:	07/29/2015	UR Denial Date:	12/16/2014
Priority:	Standard	Application Received:	01/12/2015

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: Texas, California
 Certification(s)/Specialty: Family Practice

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This is a 65 year old female patient who sustained an industrial injury on 9/16/02. Diagnoses include right shoulder pain and lower back pain. Per the primary treating physician's progress note dated 12/02/14 she had complaints of right shoulder and lower back pain. The physical examination revealed right shoulder- limited range of motion and tenderness; lower back - tenderness and very slow gait. Work status is retired. The medications list includes soma, naproxen and Tylenol #3. Other therapy done for this injury was not specified in the records provided. Plan of care includes: massage therapy with electrical stimulation and hot/cold packs and continue prescribed medications; Soma 350 mg 1 at night #30, Tylenol #3 1 twice per day #30 and Naproxen 550 mg 1 twice per day with food #60.

IMR ISSUES, DECISIONS AND RATIONALES

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

Soma 350mg 1 by mouth every night at bedtime, QTY: 30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol (Soma), page 29, Muscle relaxants (for pain), page 64.

Decision rationale: Soma 350mg 1 by mouth every night at bedtime, QTY: 30. According to California MTUS, Chronic pain medical treatment guidelines, Carisoprodol (Soma) is a muscle relaxant and it is not recommended for chronic pain. Per the guidelines, "Carisoprodol is not indicated for long-term use. It has been suggested that the main effect is due to generalized sedation and treatment of anxiety." California MTUS, Chronic pain medical treatment guidelines recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP. Per the guideline, "muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in most LBP cases, they show no benefit beyond NSAIDs in pain and overall improvement. Also there is no additional benefit shown in combination with NSAIDs. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. Sedation is the most commonly reported adverse effect of muscle relaxant medications." The CA MTUS chronic pain guidelines do not recommended soma for long term use. The need for soma-muscle relaxant on a daily basis with lack of documented improvement in function is not fully established. Response to NSAIDs without muscle relaxants is not specified in the records provided. Evidence of acute exacerbation or muscle spasm is not specified in the records provided. The Soma 350mg 1 by mouth every night at bedtime, QTY: 30 is not medically necessary in this patient at this time.

Tylenol #3, 1 by mouth, two (2) times per day QTY: 60: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Goodman Gilman's The Pharmacological Basis of Therapeutics, 12th ed. McGraw Hill, 2006, and Non-MTUS website Physician's Desk Reference, 68th ed. www.RxList.com. Non-MTUS website ODG Workers Compensation Drug Formulary, www.odg-twc.com/odgtwc/formulary.htm and Non-MTUS website drugs.com and Non-MTUS website Epocrates Online, www.online.epocrates.com and Non-MTUS website Monthly Prescribing Reference, www.empr.com and Non-MTUS website AMDD Agency Medical Directors' Group Dose Calculator, www.agencymeddirectors.wa.gov.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CRITERIA FOR USE OF OPIOIDS Page 75-80.

Decision rationale: Tylenol #3, 1 by mouth, two (2) times per day QTY: 60. Tylenol #3 contains codeine and acetaminophen. Codeine is an opioid analgesic. According to the cited guidelines, "A therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Before initiating therapy, the patient should set goals, and the continued use of opioids should be contingent on meeting these goals." The records provided do not specify that that patient has set goals regarding the use of opioid analgesic. The treatment failure with non-opioid analgesics is not specified in the records provided. Other criteria for ongoing management of opioids are: "The lowest possible dose should be prescribed to improve pain and function. Continuing review of overall situation with regard to nonopioid means of pain control. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects...Consider the use of a urine drug screen to assess for the use or the presence of illegal drugs." The records provided do not provide a documentation of response in regards to pain control and objective functional improvement to opioid analgesic for this patient. The continued review of the overall situation with regard to non-opioid means of pain control is not documented

in the records provided. As recommended by the cited guidelines a documentation of pain relief, functional status, appropriate medication use, and side effects should be maintained for ongoing management of opioid analgesic, these are not specified in the records provided. Response to antidepressant, anticonvulsant or lower potency opioid for chronic pain is not specified in the records provided. A recent urine drug screen report is not specified in the records provided. This patient does not meet criteria for ongoing continued use of opioids analgesic. The Tylenol #3, 1 by mouth, two (2) times per day QTY: 60 is not medically necessary for this patient, based on the clinical information submitted for this review and the peer reviewed guidelines referenced. If this medication is discontinued, the medication should be tapered, according to the discretion of the treating provider, to prevent withdrawal symptoms.

1 massage therapy with electrical stimulation and hot/cold packs for the right shoulder:
Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder (Acute & Chronic).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300 Physical methods, Chronic Pain Treatment Guidelines Massage therapy page 60, Physical therapy page 98.

Decision rationale: 1 massage therapy with electrical stimulation and hot/cold packs for the right shoulder. Per the cited guidelines "Physical modalities such as massage, diathermy, cutaneous laser treatment, ultrasound, transcutaneous electrical neurostimulation (TENS) units, percutaneous electrical nerve stimulation (PENS) units, and biofeedback have no proven efficacy in treating acute low back symptoms. Insufficient scientific testing exists to determine the effectiveness of these therapies..." Per the CA MTUS guidelines, regarding massage therapy "This treatment should be an adjunct to other recommended treatment (e.g. exercise), and it should be limited to 4-6 visits in most cases...Furthermore, many studies lack long-term follow up. Massage is beneficial in attenuating diffuse musculoskeletal symptoms, but beneficial effects were registered only during treatment. Massage is a passive intervention and treatment dependence should be avoided." In addition, per the ACOEM guidelines, "At-home local applications of heat or cold are as effective as those performed by therapists." Per the CA MTUS chronic pain guidelines, "The use of active treatment modalities (e.g., exercise, education, activity modification) instead of passive treatments is associated with substantially better clinical outcomes. In a large case series of patients with low back pain treated by physical therapists, those adhering to guidelines for active rather than passive treatments... had less pain and less disability." Response to previous conservative therapy including physical therapy and pharmacotherapy is not specified in the records provided. A valid rationale as to why remaining rehabilitation cannot be accomplished in the context of an independent exercise program is not specified in the records provided. The 1 massage therapy with electrical stimulation and hot/cold packs for the right shoulder is not medically necessary for this patient.