

<b>Case Number:</b>	CM13-0003127		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	04/17/2006
<b>Decision Date:</b>	06/03/2014	<b>UR Denial Date:</b>	07/18/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/24/2013

### 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 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:

The patient is a 50-year-old male injured on 04/17/2006, due to an undisclosed mechanism of injury. The specific injury sustained was not discussed in the documentation provided. It is noted that the patient underwent a laminectomy at L5-S1, with continued post-operative pain. The current diagnoses include lumbosacral spondylosis without myelopathy, degeneration of lumbar or lumbosacral intervertebral disc, and lumbar facet syndrome. The clinical documentation indicates that the patient underwent bilateral medical branch block with 75-80% pain relief times five (5) days. Additionally, the clinical documentation dated 03/04/14, indicated that a previous radiofrequency right lumbar facet neurotomy at L3-4, L4-5 provided 75% decrease in pain times six (6) months. The patient has failed conservative therapies to include physical therapy, anti-inflammatories, muscle relaxants, chiropractic therapy, TENS unit, and acupuncture.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **1 BILATERAL LUMBAR FUSION INJECTION: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300-301.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines ONLINE VERSION, LOW BACK COMPLAINTS; RADIOFREQUENCY NEUROTOMY, NEUROTOMY, AND FACET RHIZOTOMY. Decision based on Non-MTUS Citation MTUS:

## CHRONIC PAIN MEDICAL TREATMENT GUIDELINES - ONLINE VERSION, LOW BACK COMPLAINTS; RADIOFREQUENCY NEUROTOMY, NEUROTOMY, AND FACET RHIZOTOMY.

**Decision rationale:** The Chronic Pain Guidelines indicate that radiofrequency neurotomy, neurotomy, and facet rhizotomy is recommended for chronic low back pain. The guidelines also indicate that facet neurotomies should be performed only after appropriate investigation involving controlled differential dorsal ramus medial branch diagnostic blocks. The clinical documentation indicates that the patient underwent bilateral medical branch block with 75-80% pain relief times five (5) days. Additionally, the clinical documentation dated 03/04/14, indicated a previous radiofrequency right lumbar facet neurotomy at L3-4, L4-5 provided 75% decrease in pain for six (6) months. The patient has failed conservative therapies to include physical therapy, anti-inflammatories, muscle relaxants, chiropractic therapy, TENS unit, and acupuncture. The objective findings are consistent with facet generated pain. The patient clearly meets criteria for bilateral radiofrequency lumbar facet neurotomy; however, following clarification of the request, there is no such injection as a bilateral lumbar fusion injection. As such, the request for one (1) bilateral lumbar fusion injection cannot be recommended as medically necessary.

### **1 PRESCRIPTION FOR NORCO 10/325 MG: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS, CRITERIA FOR USE Page(s): 77.

**Decision rationale:** The Chronic Pain Guidelines indicate that patients must demonstrate functional improvement in addition to appropriate documentation of ongoing pain relief to warrant the continued use of narcotic medications. There is no clear documentation regarding the functional benefits or any substantial functional improvement obtained with the continued use of narcotic medications. The patient consistently reported elevated visual analog scale (VAS) pain scores throughout all of the clinical notes indicating a lack of pain relief indicative of lack of medication efficacy. As the clinical documentation provided for review does not support an appropriate evaluation for the continued use of narcotics as well as establish the efficacy of narcotics, the medical necessity of one (1) prescription for Norco 10/325mg cannot be established at this time.

### **1 PRESCRIPTION FOR SOMA 350 MG: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines CARISOPRODOL Page(s): 65.

**Decision rationale:** The Chronic Pain Guidelines indicate that Soma is not recommended for long-term use. This medication is FDA-approved for symptomatic relief of discomfort associated with acute pain in musculoskeletal conditions as an adjunct to rest and physical therapy. The documentation indicates that the patient is being prescribed the medication for chronic pain and long-term care exceeding the recommended treatment window. As such, the request for one (1) prescription for Soma 350 mg cannot be recommended as medically necessary at this time.

**1 PRESCRIPTION FOR MSER ( MORPHINE SULFATE ER): Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS, CRITERIA FOR USE Page(s): 77.

**Decision rationale:** The Chronic Pain Guidelines indicate that patients must demonstrate functional improvement in addition to appropriate documentation of ongoing pain relief to warrant the continued use of narcotic medications. There is no clear documentation regarding the functional benefits or any substantial functional improvement obtained with the continued use of narcotic medications. The patient consistently reported elevated visual analog scale (VAS) pain scores throughout all of the clinical notes, indicating a lack of pain relief indicative of lack of medication efficacy. As the clinical documentation provided for review does not support an appropriate evaluation for the continued use of narcotics as well as establish the efficacy of narcotics, the medical necessity of one (1) prescription for Morphine Sulfate ER (MSER) cannot be established at this time.