

<b>Case Number:</b>	CM13-0004940		
<b>Date Assigned:</b>	12/18/2013	<b>Date of Injury:</b>	08/19/2005
<b>Decision Date:</b>	01/29/2014	<b>UR Denial Date:</b>	07/19/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/31/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Emergency Medicine, and is licensed to practice in New York. 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 physician 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 49-year-old male with complaints of continuing lower back pain with radiation into his right leg with numbness. The date of injury is August 19, 2005. Physical examination results show paravertebral tenderness, especially at L and L3. The right knee jerk is absent. There are no documented motor or sensory deficits. There are no recent MRI studies available for review. There is documentation that the MRI shows disc protrusions. The level of disc protrusions and the date of MRI are not documented. The diagnosis was lumbar disc protrusion and lumbar annular tear. The patient underwent discography in 2007 and percutaneous disc compression in 2009. Treatment included medications. The current requests for authorization for right L2 and L3 selective nerve root block under fluoroscopy #1, Percocet 10/325 mg # 120, Norco 10/325 #90, and Soma 350 mg #90 were submitted on July 16, 2013.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **1 Right L2 and L3 Selective Nerve Root Block under fluoroscopy: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 46.

**Decision rationale:** According to the MTUS Chronic Pain Guidelines, epidural steroid injections are recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). Most current guidelines recommend no more than 2 ESI injections. Current recommendations suggest a second epidural injection if partial success is produced with the first injection, and a third ESI is rarely recommended. Epidural steroid injection can offer short term pain relief and use should be in conjunction with other rehab efforts, including continuing a home exercise program. There is little information on improved function. In this case the patient is experiencing right leg pain which is not clearly radiculopathy. The only objective finding is the absent right knee jerk reflex. There are no documented motor or sensory deficits. The knee jerk reflex is mediated by L3-4, mostly L4. There is no documented radiculopathy at the L2 and L3 levels and there are no corroborative imaging or electrodiagnostic studies in the medical records provided for review. There is no research based evidence for epidural injections for back pain without radiculopathy. The request for one right L2 and L3 selective nerve root block under fluoroscopy is not medically necessary and appropriate.

**One prescription of Percocet 10/325 #120: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-96.

**Decision rationale:** Percocet 10/325 is compounded medication containing oxycodone/acetaminophen. The MTUS Chronic Pain Guidelines state that opioids are not recommended as a first line therapy. The Guidelines identify criteria for the use of Opioids, including establishment of a treatment plan, determination if pain is nociceptive or neuropathic, failure of pain relief with non-opioid analgesics, setting of specific functional goals, and opioid contract with agreement for random drug testing. In this case, the patient was also prescribed two opioid medications. This increases the risk of adverse effects, including dependency. In addition, the medication was not prescribed for short term use and the criteria for opioid use were not met. Furthermore, the guidelines state that "Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." Consequently, the request for one prescription of Percocet 10/325 #120 is not medically necessary and appropriate.

**One prescription of Norco 10/325mg #90: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 11, 74-96.

**Decision rationale:** Norco is a compounded medication containing hydrocodone and acetaminophen. The MTUS Chronic Pain Guidelines state that opioids are not recommended as a first line therapy. The Guidelines identify criteria for the use of Opioids, including establishment of a treatment plan, determination if pain is nociceptive or neuropathic, failure of pain relief with non-opioid analgesics, setting of specific functional goals, and opioid contract with agreement for random drug testing. In this case, the patient was also prescribed two opioid medications. This increases the risk of adverse effects, including dependency. In addition, the medication was not prescribed for short term use and the criteria for opioid use were not met. Furthermore, the guidelines state that "Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." The request for one prescription of Norco 10/325mg #90 is not medically necessary and appropriate.

**One prescription of Soma 350mg #90:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 29.

**Decision rationale:** Soma is the medication carisoprodol. According to the MTUS Chronic Pain Guidelines, Carisoprodol is not recommended for long term use. Carisoprodol is a commonly prescribed, centrally acting skeletal muscle relaxant whose primary active metabolite is meprobamate (a schedule-IV controlled substance). The MTUS Chronic Pain Guidelines do not recommend muscle relaxants for a shoulder injury. The request for one prescription of Soma 350mg #90 is not medically necessary and appropriate.