

<b>Case Number:</b>	CM13-0053746		
<b>Date Assigned:</b>	04/23/2014	<b>Date of Injury:</b>	04/01/2013
<b>Decision Date:</b>	05/23/2014	<b>UR Denial Date:</b>	11/06/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/18/2013

### 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 Physical Medicine and Rehabilitation, has a subspecialty in Neuromuscular Medicine and is licensed to practice in Maryland. 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 30 year old male with a work injury dated 4/1/13 to his low back. He complains of chronic low back pain radiating down his left lower extremity. The documentation indicates that he has a herniated nucleus pulposus at L4-5 and left lower extremity radiculopathy. There is also a possible bilateral pars fracture at L5-S1. He additionally has a right L3-4 foraminal disc herniation and anxiety/depression. A 10/22/13 primary treating physician (orthopedic surgery) progress states that the patient complains of constant low back pain, rated 8/10, with numbness and tingling to the left leg and right buttock. He also complains of anxiety. In addition, he notes that his anxiety is due to his pain. He also notes that his anxiety is due to the difficulty that he has because he cannot return to work. His lumbar epidural steroid injection has been approved by the insurance carrier. However, the schedule is still pending. On physical examination of the lumbar spine there are paraspinal spasms and tenderness, there is weakness in the left extensor hallucis longus and tibialis anterior at 3/5. There is a positive straight leg raise test on the left side. The treatment plan includes a request for a chronic pain management doctor since he is consuming a significant amount of opioids to help him with his pain. There are requests for Norco and Soma. The document indicates that the patient is temporarily totally disabled. An 11/19/13 primary treating physician progress report indicates that the patient complains of constant sharp back pain, rated 8/10, with radiation to the left lower extremity down into the foot, with associated numbness sensation. He states that his low back pain feels the same since his last visit. He also reports psychiatric symptoms of anxiety, depression, stress, and insomnia. His current medications include Norco and Soma. Physical exam of the lumbar spine indicates paraspinal spasms and tenderness. There is weakness of the left extensor hallucis longus and tibialis anterior at 3/5. Straight leg raise test is positive on the left. There is sciatic notch tenderness on the left.

Range of motion is restricted. At this point, the patient been approved for an epidural steroid injection. He has fears about the epidurals given the possible risks. He would like to have a chronic pain management first, so the provider is requesting a chronic pain management for him as he does have severe pain which needs to be monitored by a pain management specialist. The provider also is recommending surgical management for his lumbar spine. He would like to have a spinal second opinion. Two prior utilization reviews have non-certified both Soma due to the MTUS criteria that this is not for long term use and also there is a non certification of a chronic pain management referral. The referral was denied on most recent review dated the review states that a consult is recommended when pain persists but tissue pathology is minimal.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **CHRONIC PAIN MANAGEMENT REFERRAL: Overturned**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management, Chapter 15 Stress Related Conditions Page(s): 398.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 92, Chronic Pain Treatment Guidelines PAIN OUTCOMES AND ENDPOINTS Page(s): 8.

**Decision rationale:** A chronic pain management referral is medically necessary per the American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) guidelines. The guidelines state that referral may be appropriate if the practitioner is uncomfortable with the line of inquiry outlined in Chapter 5 of the ACOEM, with treating a particular cause of delayed recovery (such as substance abuse), or has difficulty obtaining information or agreement to a treatment plan. The documentation indicates that the physician feels that the patient has a significant amount of pain and needs to be evaluated by a pain specialist. Additionally the MTUS Chronic Pain Medical Treatment guidelines state that the physician should periodically review the course of treatment of the patient and any new information about the etiology of the pain or the patient's state of health. The MTUS states that modification of pain management depends on the physician's evaluation of progress toward treatment objectives. If the patient's progress is unsatisfactory, the physician should assess the appropriateness of continued use of the current treatment plan and consider the use of other therapeutic modalities. When prescribing controlled substances for pain, the MTUS states that satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. The documentation indicates that patient is having unsatisfactory pain levels, no significant functional improvement and therefore a referral to a chronic pain management specialist is medically necessary and appropriate.

#### **SOMA 350MG #52: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines CARISOPRODOL (SOMA  $\frac{1}{2}$ ), Page(s): 29.

**Decision rationale:** Soma is not medically necessary per the MTUS guidelines. The MTUS Chronic Pain Medical Treatment Guidelines state that Soma is not indicated for long-term use. Prior utilization review recommended tapering Soma. The request for the continuation of Soma is not medically necessary or appropriate. The documentation submitted shows that a prior utilization review on 11/6/13 indicated that Soma was not for long term and recommended tapering. The request for Soma 350mg #52 is not medically necessary.