

Case Number:	CM14-0011610		
Date Assigned:	02/21/2014	Date of Injury:	04/17/2006
Decision Date:	08/07/2014	UR Denial Date:	01/22/2014
Priority:	Standard	Application Received:	01/29/2014

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. The expert reviewer is Board Certified in Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in Tennessee. 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:

This is a 50-year-old male patient with a 4/17/06 date of injury. A 12/5/13 progress report indicated that the patient complained of lower back pain. He had positive pain relief with previous lumbar transforaminal ESI with 55% relief, but since then the pain has slowly returned, 7/10. He described his pain as sharp with intermittent spasm and weakness. He also reported positive pain relief for 75-80% after previous lumbar facet injection for 5 days. Physical exam revealed bilateral tenderness of lumbar spine from L3-L5. There was lumbar facet tenderness at L3-L4 and L4-L5. Range of motion was limited in the lumbar spine and there was no evidence of lumbar radiculopathy. He was diagnosed with Lumbar spondylosis without myelopathy, Bilateral lumbar facet syndrome, Mechanical low back pain, Status post diagnostic lumbar facet injection with positive result and Failed conservative therapies for pain control (physical therapy modalities, chiropractic treatment, anti-inflammatory medications, and muscle relaxants) for more than twelve weeks. Treatment to date: recommended for radio frequency bilateral lumbar facet neurotomy (previous was on 10/23/12), home exercise program, and Left lumbar L3-L4 transforaminal epidural injection on 11/13/13. There is documentation of a previous 1/22/14 adverse determination, based on the fact that there was no documentation of functional improvement, Norco and MSER were not certified. Because Soma was not recommended for long-term use, it was not certified. There was also no documentation of 50% pain relief for 12 weeks after lumbar facet neurotomy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325 mg, #180: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines (May 2009).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78-81.

Decision rationale: CA MTUS Chronic Pain Medical Treatment Guidelines do not support ongoing opioid treatment unless prescriptions are from a single practitioner and are taken as directed; are prescribed at the lowest possible dose; and unless there is ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. However, there was no documentation supporting of significant pain relief or functional gains. In addition, there was no urine drug screen test available or documentation of an opiate pain contract. Therefore, the request for Norco 10/325 mg, #180 was not medically necessary.

MSER 15 mg, #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines (MAY 2009).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78-81.

Decision rationale: CA MTUS Chronic Pain Medical Treatment Guidelines do not support ongoing opioid treatment unless prescriptions are from a single practitioner and are taken as directed; are prescribed at the lowest possible dose; and unless there is ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. However, there was no documentation supporting of significant pain relief or functional gains. In addition, there was no documentation of CURES monitoring, urine drug screens, or opiate pain contract. Therefore, the request for MSER 15 mg, #60 was not medically necessary.

Soma 350 mg, #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines (MAY 2009).

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

Decision rationale: CA MTUS states that Soma is not indicated for long-term use. Carisoprodol is a commonly prescribed, centrally-acting skeletal muscle relaxant and is now scheduled in several states. 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 is metabolized to meprobamate, an anxiolytic that is a schedule IV controlled substance. Soma has been known to augment or alter the effects of other medications, including opiates and

benzodiazepines. However, this patient is also noted to be on Norco and extended-release Morphine, and Soma can increase and augment the effect of these medications, increasing sedation and respiratory depression. Therefore, the request for Soma 350 mg, #90 was not medically necessary.

Bilateral radiofrequency lumbar facet neurotomy: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300-301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter.

Decision rationale: ODG criteria for RFA include evidence of adequate diagnostic blocks, documented improvement in VAS score, documented improvement in function, evidence of a formal plan of additional evidence-based conservative care in addition to facet joint therapy, at least 12 weeks at 50% relief with prior neurotomy, and repeat neurotomy to be performed at an interval of at least 6 months from the first procedure. There was documentation of 50-75% pain relief for only 5 days. However, guidelines recommended repeat neurotomy if positive result stayed at least 12 weeks. Therefore, the request for bilateral radiofrequency lumbar facet neurotomy was not medically necessary.