

<b>Case Number:</b>	CM14-0170012		
<b>Date Assigned:</b>	10/20/2014	<b>Date of Injury:</b>	10/23/1996
<b>Decision Date:</b>	12/31/2014	<b>UR Denial Date:</b>	10/03/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/15/2014

### 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 Physical Medicine and Rehabilitation, has a subspecialty in Interventional Spine, 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:

This female patient with an unknown age reported an injury date on 10/23/1996. Based on the 09/16/2014 progress report provided by the treating physician, the diagnoses are: 1. Degenerative disc disease of the lumbosacral spine and bilateral L4-5 and L5-S1 radiculopathy 2. Rule out lumbar facet syndrome at L4-S1 bilaterally 3. Degenerative disc disease and herniated nucleus pulposus of the cervical spine; rule out bilateral C5-6 radiculopathy. According to this report, the patient complains of "ongoing pain to her neck and low back." Patient's "pain can be as high as a 6-7 in a 1-10 pain scale, but with the use of medication, this is reduced this down to a 3." Physical exam reveals pain to palpation at the L4- S1 paraspinal musculature, bilateral. Reflex of the right patella is a 1+, left patella is a 2+, and bilateral ankle is a 2+. Motor strength of the bilateral knee, left dorsiflexion, and plantar flexion is a 4/5; and right dorsiflexion is a 3/5. Patient's treatment history included "low back injections, which have helped to reduce her pain 50% for three months." There were no other significant findings noted on this report. The utilization review denied the request for Norco 10/325 #180, Prilosec 20mg #60, and Soma 350mg #60 on 10/03/2014 based on the MTUS/ODG guidelines. The requesting physician provided treatment reports from 01/14/2014 to 07/15/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Norco 10/325 #180 for muscle relaxation and spasm: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medications for chronic pain, CRITERIA FOR USE OF OPIOIDS Page(s): 60, 61, 88, 89, 76-78.

**Decision rationale:** According to the 09/16/2014 report, this patient presents with "ingoing pain to her neck and low back." Per this report, the current request is for Norco 10/325 #180 for muscle relaxation and spasm. This medication was first mentioned in the 01/14/2014 report; it is unknown exactly when the patient initially started taking this medication. For chronic opiate use, MTUS Guidelines pages 88 and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4As (analgesia, ADLs, adverse side effects, and aberrant behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. Review of the 09/16/2014 report, the treating physician mentions patient's "pain can be as high as a 6-7 in a 1-10 pain scale, but with the use of medication, this is reduce this down to a 3." There is "no side effects with the use of medications other than some stomach upset, which is relieved with the use of Prilosec." The treating physician recommended the patient to "continue with home exercise" and "the use of medications, which help her to better perform activities of daily living and improve her level of functioning." In this case report shows documentation of analgesia with pain ranging from 7/10 to 3/10 the use of medication. ADL's were mentioned but the treating physician does not discuss specific improvement in ADLs or document specific functional improvement. No return to work or opiate monitoring is discussed such as urine toxicology and CURES. Outcome measures are not documented as required by MTUS. No valid instruments are used to measure the patient's function which is recommended once at least every 6 months per MTUS. The treating physician has failed to properly document ADL's and Adverse behavior as required by MTUS. Recommendation is for denial.

**Prilosec 20mg #60:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines PPI: NSAIDs, GI symptoms & cardiovascular risk Page(s): 69.

**Decision rationale:** According to the 09/16/2014 report, this patient presents with "ingoing pain to her neck and low back." Per this report, the current request is for Prilosec 20mg #60. This medication was first mentioned in the 01/14/2014 report; it is unknown exactly when the patient initially started taking this medication. The MTUS page 69 states under NSAIDs prophylaxis to discuss, GI symptoms & cardiovascular risk and recommendations are with precautions as indicated below. "Clinicians should weigh the indications for NSAIDs against both GI and cardiovascular risk factors. Determine if the patient is at risk for gastrointestinal events: (1) age

> 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA). "MTUs further states "Treatment of dyspepsia secondary to NSAID therapy: Stop the NSAID, switch to a different NSAID, or consider H2-receptor antagonists or a PPI." Review of report show that the patient has gastrointestinal side effects with medication use. Patient is currently not on NSAID and the treating physician briefly mentions upset stomach. However, there is no discussion regarding GI assessment as required by MTUS. MTUS does not recommend routine use of GI prophylaxis without documentation of GI risk. In addition, the treater does not mention symptoms of gastritis, reflux or other condition that would require a PPI. Recommendation is for denial.

**Soma 350mg #60 for muscle relaxation and spasm: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants and (for pain) Page(s): 64, 63.

**Decision rationale:** According to the 09/16/2014 report, this patient presents with "ingoing pain to her neck and low back." Per this report, the current request is for Soma 350mg #60 for muscle relaxation and spasm. For muscle relaxants for pain, the MTUS Guidelines page 63 state "Recommended non-sedating muscle relaxants with caution as a second line option for short term treatment of acute exacerbation in patients with chronic LBP. Muscle relaxants may be effective in reducing pain and muscle tension and increasing mobility; however, in most LBP cases, they showed no benefit beyond NSAIDs and pain and overall improvement." A short course of muscle relaxant may be warranted for patient's reduction of pain and muscle spasms. Review of available records indicate this patient has been prescribed this medication longer than the recommended 2-3 weeks. The treating physician is requesting Soma #60 and this medication was first noted in the 01/14/2014 report. Soma is not recommended for long term use. The treater does not mention that this is for a short-term use to address a flare-up or an exacerbation. Therefore, recommendation is for denial.