

Case Number:	CM14-0021659		
Date Assigned:	05/07/2014	Date of Injury:	04/25/2011
Decision Date:	07/29/2014	UR Denial Date:	02/11/2014
Priority:	Standard	Application Received:	02/20/2014

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 Pain Medicine 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 41-year-old male with a 4/25/11 date of injury, from a lifting injury. A 1/24/14 progress note described 10/10 low back pain radiating into the lower extremities, numbness and constant pain in the left knee. The patient utilizes a knee brace. There was tenderness and reduced range of motion in the spine and left knee. Current medications include Percocet, Ativan, Nuerontin, clonidine, Soma, Lovastatin, and Depakote. The patient participates in home exercise program. A 4/18/14 progress note described constant low back pain and left knee pain (9-10/10). Clinically, there was positive straight leg raise. The patient is scheduled for a total knee arthroplasty on the left.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 SOMA 350 MG #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines : CHRONIC PAIN MEDICAL TREATMENT GUIDELINES.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CA MTUS 2009: 9792.24.2. ; FDA (Carisoprodol) Page(s): 29,65.

Decision rationale: Medical necessity for Soma has not been established. The CA MTUS states that Soma is not recommended. Carisoprodol is metabolized to meprobamate an anxiolytic that is

a schedule IV controlled substance. Clinically, there were no documented muscle spasms, no discussion regarding duration of use in this 2011 date of injury, or discussion of efficacy in reducing pain, as well as functional benefits. Prior adverse determination was based on lack of documented flare up or muscle spasms. As prior notes did not mention the use of Soma, weaning was not felt necessary. As guideline criteria was not met, the request remains unsubstantiated. As such, the request is not medically necessary.

1 NORCO 10/325 MG#180: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines : CHRONIC PAIN MEDICAL TREATMENT GUIDELINES.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment Guidelines, pages 79-81 and on the Non-MTUS Opioid Therapy for Chronic Pain website: www.americanpainsociety.org.

Decision rationale: The medical necessity for the requested opioid is not established. The request obtained an adverse determination due to lack of documented improvement in pain or functional gains, attributed to this medication. The patient continues to complain of significant pain, and no reduction in visual analogue scale scores with medication use has been discussed. The CA MTUS requires documentation of continued analgesia, continued functional benefit, a lack of adverse side effects, or aberrant behavior, as well as assessment of compliance utilizing random urine drug screens and a pain contract. The medical necessity is unsubstantiated. As such, the request is not medically necessary.

1 EXTRA LARGE LUMBER SACRAL ORTHOSIS BACK BRACE: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS American College of Occupational and Environmental Medicine (ACOEM), chapter 12: Low Back Complaints, page 301 and on the Non-MTUS Official Disability Guidelines (ODG), Pain chapter: Back Brace.

Decision rationale: The medical necessity for the requested back brace is not established. The CA MTUS states that lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief, however, the ODG identifies that back braces are recommended as an option for compression fractures and specific treatment of spondylolisthesis, documented instability, but is under study for post-operative use. It has not been documented that the patient has instability in the low back, and the low back injury is beyond the acute injury phase. The request is not substantiated.

1 LUMBER CAUDAL EPIDURAL STEROID INJECTION WITH LUMBER DECOMPRESSION: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines : CHRONIC PAIN MEDICAL TREATMENT GUIDELINES.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300,Chronic Pain Treatment Guidelines CA MTUS 9792.24.2 Page(s): 46.

Decision rationale: The medical necessity for the requested lumbar ESI is not established, as guideline criteria has not been met. The CA MTUS does not support epidural injections in the absence of objective radiculopathy. Clinically, there were no focal neurological deficits. Without clinical evidence of sensory, motor, or reflex loss. Furthermore, there is no imaging confirming anatomic nerve impingement or electrodiagnostic testing, confirming radiculopathy. The request is not substantiated.

