

<b>Case Number:</b>	CM14-0064753		
<b>Date Assigned:</b>	07/11/2014	<b>Date of Injury:</b>	04/09/2010
<b>Decision Date:</b>	09/19/2014	<b>UR Denial Date:</b>	04/10/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/07/2014

### 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 Occupational 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 applicant is a represented [REDACTED] employee who has filed a claim for chronic low back pain reportedly associated with an industrial injury of April 9, 2010. Thus far, the applicant has been treated with the following: Analgesic medications; multiple lumbar spine surgeries; a spinal cord stimulator implantation; hip surgery; and opioid therapy. In a Utilization Review Report dated April 10, 2014, the claims administrator approved a pain management consultation, refilled a one-month supply of Norco, approved a request for Neurontin, and approved a urine drug screen while denying a pain management referral, Percocet, Soma, Biofreeze gel, and trigger point injection therapy. The applicant's attorney subsequently appealed. In a May 7, 2014 office visit, the applicant reported severe low back pain with radiation to his legs. The applicant's usage of Percocet was generally minimal-to-no improvement, it was acknowledged. The applicant reported dizziness. The applicant stated that Percocet was only taking the edge off of his pain. The applicant is using a cane. Lumbar range of motion was 10% of normal. Lower extremity strength ranged from 4+-5/5. Percocet, Soma, and Neurontin were endorsed. The applicant was awaiting a pain management consultation. The applicant was retired. The applicant was also considering/pending further lumbar spine surgery, it was stated. On April 23, 2014, the applicant reported severe low back pain resulting in using a wheelchair. The applicant exhibited an antalgic gait in the clinic setting. Percocet, Soma, and Neurontin were prescribed. Norco was discontinued on the grounds that it was not effective. On March 19, 2014, the applicant was asked to consult a physician for pain medication management. Norco was refilled. Percocet was added for breakthrough pain. Neurontin, Soma, Biofreeze gel, and urine drug screen were ordered. The applicant was described as having retired. Severe mid and low back pains were appreciated. On February 3, 2014, the applicant's medication list was not clearly stated. On March 19, 2014, the applicant did receive trigger point injection therapy.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **Pain Management Treatment, Medication Management:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 92.

**Decision rationale:** As noted in the MTUS-adopted ACOEM Guidelines in Chapter 5, page 92, referrals may be appropriate if an attending provider is uncomfortable treating a particular cause of delayed recovery. In this case, the applicant's primary treating provider, a spine surgeon, has indicated that he is ill-equipped to handle the applicant's medication management issues. The applicant has chronic and severe low back complaints which have proven recalcitrant to a variety of opioid and nonopioid options. Obtaining the added expertise of a physician specializing in medication management and chronic pain such as a pain management physician is indicated. Therefore, the request is medically necessary.

### **Percocet 10mg 1 month supply:** Overturned

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

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

**Decision rationale:** The request for Percocet represented a first-time request as of the date of the Utilization Review Report, April 10, 2014, and as of the date of the request, March 19, 2014. The applicant's primary treating provider introduced Percocet on the grounds that earlier usage of Norco had proven insufficient to combat the applicant's pain complaints. As noted on page 91 of the MTUS Chronic Pain Medical Treatment Guidelines, short-acting opioid such as Percocet are often used for breakthrough pain. In this case, the applicant did indeed have breakthrough pain at the severe level. Provision of Percocet to ameliorate the same was indicated. Therefore, a one-month supply of the same was medically necessary.

### **Soma 350mg, q22h prn - 1 month supply:** Upheld

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

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

**Decision rationale:** As noted on page 29 of the MTUS Chronic Pain Medical Treatment Guidelines, carisoprodol or Soma is not recommended for chronic or long-term use purposes, particularly when compliant with opioid agents. In this case, the applicant is, in fact, using a variety of opioids, including Percocet and Norco. Adding Carisoprodol or Soma to the mix for the long term, chronic, and scheduled use purpose for which is being proposed is not indicated. Therefore, the request is not medically necessary.

**Biofreeze:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 299.

**Decision rationale:** As noted in the MTUS-adopted ACOEM Guidelines in Chapter 12, Table 12-5, page 299, applications of low-tech, at-home local applications of heat and cold are recommended as methods of symptom control for low back complaints. The Biofreeze gel at issue does represent a low-tech, simple, inexpensive at-home local application of cold therapy. Provision of the same is indicated, given the applicant's persistent low back pain complaints. Therefore, the request is medically necessary.

**Trigger Point Injections:** 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 Trigger Point Injections topic Page(s): 122.

**Decision rationale:** As noted on page 122 of the MTUS Chronic Pain Medical Treatment Guidelines, trigger point injections are indicated only for myofascial pain syndrome, with limited lasting value. They are not recommended in the treatment of radicular pain. In this case, the applicant was described as having persistent complaints of radicular low back pain radiating to the legs on several office visits, reference above, including on May 7, 2014 and on April 23, 2014. Trigger point injection therapy is not recommended to combat the same. The applicant, furthermore, is contemplating further spine surgery, again suggesting that his primary pain generator is radicular/sciatic low back pain. The trigger point injections performed on March 19, 2014 were therefore not medically necessary.