

<b>Case Number:</b>	CM14-0194240		
<b>Date Assigned:</b>	12/02/2014	<b>Date of Injury:</b>	09/06/2003
<b>Decision Date:</b>	01/16/2015	<b>UR Denial Date:</b>	10/27/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/20/2014

### 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 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 54 year old male with a work injury dated 9/6/03. The diagnoses include lumbago, lumbar disc displacement, lumbosacral disc degeneration; failed back surgery syndrome, bilateral sacroilitis, myofascial pain, lumbar facet joint pain; chronic low back pain. Under consideration are requests for Percocet 10/325mg #120; Soma 350mg #90 x 3 refills; Ibuprofen 600mg #60 x 3 refills; Valium 5mg #30 x 3 refills; Neurontin 300mg #60 x 3 refillsMRI of 9/27/2010 shows lumbar disc degeneration throughout L1-S1, and verified alignment and ruled out stenosis at L4-5/L5-S1fusions. No current MRI is available. A 10/17/14 progress note states that the patient complains of left low back pain that radiates to her left lower extremity and the front of her right groin area. She reports intermittent numbness and burning throughout her entire bilateral lower extremities. She is scheduled to have L5-S1 fusion on 11/3/14. She states her pain level without medications is10/10 and 7-8/10 with medications. She reports there are no significant changes from her last office visit. Medications are beneficial, no reported side effects. Her medications include Soma, Percocet, and Ibuprofen. On exam there is moderate tenderness with palpation diffusely over L2-3, L3-4 lumbosacral region with moderate to severe tenderness to palpation over bilateral sacroiliac joints, right greater than left. Lumbar range of motion is 100% restricted in all planes, positive straight leg rise. There are dysesthesias and hypoesthesia in bilateral lower extremities, left greater than right. The medications were Percocet, Ibuprofen, Soma, Valium, and Neurontin. A 3/21/14 progress note states that the patient was prescribed Percocet, Soma, and Ibuprofen.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Percocet 10/325mg #120: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines On-Going Management of Opioids Page(s): 78-80.

**Decision rationale:** Percocet 10/325mg #120 is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The MTUS Chronic Pain Medical Treatment Guidelines state that a pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. The MTUS does not support ongoing opioid use without improvement in function or pain. The documentation submitted reveals evidence of the above criteria including that the patient has significant functional improvement or significant analgesia despite being on Percocet long term therefore the request for Percocet 10/325mg #120 is not medically necessary.

**Soma 350mg #90 x 3 refills: Upheld**

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

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

**Decision rationale:** Soma 350mg #90 x 3 refills is not medically necessary per the MTUS and ODG Guidelines. Both guidelines recommend against using Soma and state that it is not for long term use. The MTUS and ODG guidelines state that abuse has been noted for sedative and relaxant effects. Soma abuse has also been noted in order to augment or alter effects of other drugs. The documentation indicates that the patient has been on Soma long term which is against guideline recommendations. There are no extenuating circumstances that would warrant the continuation of this medication. The request for Soma is not medically necessary.

**Ibuprofen 600mg #60 x 3 refills: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (Non-Steroidal Anti-Inflammatory Drugs) Page(s): 67-73.

**Decision rationale:** Ibuprofen 600mg #60 x 3 refills is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The guidelines state that NSAIDs are recommended as an option at the lowest dose for short-term symptomatic relief of chronic low back pain, osteoarthritis pain, and for acute exacerbations of chronic pain. The documentation indicates that the patient has been on NSAIDs for an extended period without evidence of functional improvement and with persistent pain. The request for continued Ibuprofen is not medically necessary as there is no evidence of long-term effectiveness of NSAIDs for pain or function. Additionally NSAIDs have associated risk of adverse cardiovascular events, new onset or worsening of pre-existing hypertension, ulcers and bleeding in the stomach and intestines at any time during treatment, elevations of one or more liver enzymes may occur in up to 15% of patients taking NSAIDs and may compromise renal function. The request for continued Ibuprofen is not medically necessary.

**Valium 5mg #30 x 3 refills:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

**Decision rationale:** Valium 5mg #30 x 3 refills is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The guidelines state that benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. Their range of action includes sedative/hypnotic, anxiolytic, anticonvulsant, and muscle relaxant. Tolerance to anticonvulsant and muscle relaxant effects occurs within weeks. The documentation indicates that the patient has been on Valium longer than the recommended 4 week. The documentation does not indicate extenuating circumstances which would necessitate going against guideline recommendations. The request for Valium is not medically necessary.

**Neurontin 300mg #60 x 3 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Epilepsy Drugs.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Epilepsy Drugs (AEDs) Page(s): 16-22.

**Decision rationale:** Neurontin 300mg #60 x 3 refills is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The guidelines state that after initiation of anti-epileptics such as Neurontin treatment there should be documentation of pain relief and improvement in function as well as documentation of side effects incurred with use. The documentation indicates that the patient has been on Neurontin long term without any significant evidence of functional improvement on the documentation submitted. Additionally, the request

for 3 refills is not appropriate as continued use of this medication would depend on efficacy. Therefore the request for Neurontin 300mg #60 x 3 refills is not medically necessary.