

Case Number:	CM15-0108934		
Date Assigned:	06/15/2015	Date of Injury:	01/30/1999
Decision Date:	08/04/2015	UR Denial Date:	05/04/2015
Priority:	Standard	Application Received:	06/05/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: New York
 Certification(s)/Specialty: Anesthesiology

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 injured worker (IW) is a 51 year old female who sustained an industrial injury on 01/30/1999. She reported twisting her back at work while lifting a rack of glasses and feeling a sharp pain. She had persistent back pain that radiated to the left lower extremity. The injured worker was diagnosed as having clinically consistent lumbar radiculopathy; myofascial pain; sacroiliitis, and lumbar sprain. Treatment to date has included EMG/NCS, lumbar epidural block and Toradol injection. Currently, the injured worker complains of spasms in the back and legs pain. She also complains of consistent left hip pain and left sacroiliac pain. The low back pain is a 7/10. Objective findings include an increase of pain with flexion of the back. The pain is in her left leg radiating to the foot. Medications and activity modifications help. The treatment plan is to continue medications and exercise. Current medications are MS Contin ER 15mg #60, Norco 10/325mg #120, Soma 350mg #30. A request for authorization was made for the above medications and for a Left Sacroiliac Joint Injection.

IMR ISSUES, DECISIONS AND RATIONALES

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

MS Contin ER 15mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, specific drug list; On-Going Management; Weaning of Medications Page(s): 92-94, 78-80, 124.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for the treatment of chronic pain Page(s): 91-97.

Decision rationale: According to ODG and MTUS, MS Contin ER(Morphine Sulfate Extended-Release) is a controlled-release preparation that should be reserved for patients with chronic pain, who are in need of continuous treatment. The treatment of chronic pain with any opioid analgesic requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. A pain assessment should include current pain, intensity of pain after taking the opiate, and the duration of pain relief. For opioids, such as MS Contin, to be supported for longer than 6 months, there must be documentation of decreased pain levels and functional improvement. A satisfactory response to treatment may be indicated by decreased pain, increased level of function, and/or improved quality of life. In this case, there was no evidence of functional benefit or response to ongoing analgesic therapy, to support continuation of this medication. Medical necessity of the requested medication has not been established. Of note, discontinuation of MS Contin should include a taper, to avoid withdrawal symptoms. The requested medication is not medically necessary.

Norco 10/325mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, specific drug list; Criteria for use of Opioids; Weaning of Medications Page(s): 91, 76-80, 124.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for the treatment of chronic pain Page(s): 91-97. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Opioids.

Decision rationale: According to the CA MTUS and ODG, Norco 10/325mg (Hydrocodone/Acetaminophen) is a short-acting opioid analgesic indicated for moderate to moderately severe pain, and is used to manage both acute and chronic pain. The treatment of chronic pain with any opioid analgesic requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. A pain assessment should include current pain, intensity of pain after taking the opiate, and the duration of pain relief. In this case, there is no documentation of the medication's functional benefit. Medical necessity of the requested item has not been established. Of note, discontinuation of an opioid analgesic should include a taper, to avoid withdrawal symptoms. The requested medication is not medically necessary.

Soma 350mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol (Soma), Muscle relaxants (for pain) Page(s): 29, 63.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 29, 63.

Decision rationale: The CA MTUS does not recommend muscle relaxants for chronic pain. Non-sedating muscle relaxants are an option for short term exacerbations of chronic low back pain. Soma (Carisoprodol) is the muscle relaxant requested in this case. This medication is sedating. No reports show any specific and significant improvements in pain or function as a result of prescribing muscle relaxants. According to the MTUS guidelines, Soma is categorically not recommended for chronic pain, noting its habituating and abuse potential. Medical necessity for the requested medication has not been established. The requested medication is not medically necessary.

Left Sacroiliac Joint Injection: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Hip & Pelvis, Online Version, Sacroiliac joint blocks.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) SIJ Block.

Decision rationale: Sacroiliac joint injections (SIJ) are recommended as an option if the patient has failed at least 4-6 weeks of aggressive conservative therapy. Sacroiliac dysfunction is poorly defined and the diagnosis is often difficult to make due to the presence of other low back pathology (including spinal stenosis and facet arthropathy). The diagnosis is also difficult to make as pain symptoms may depend on the region of the SI joint that is involved (anterior, posterior, and/or extra-articular ligaments). Pain may radiate into the buttock, groin and entire ipsilateral lower limb, although if pain is present above L5, it is not thought to be from the SI joint. Criteria for the use of SIJ blocks include that the patient has had and failed at least 4-6 weeks of aggressive conservative therapy including, physical therapy (PT), home exercise and medication management. In this case, a sacroiliac joint injection was requested on 02/19/15 and it is unclear if this was performed and what the patient's response to this procedure was. Medical necessity for the left SIJ injection has not been established. The requested left SIJ injection is not medically necessary.