

<b>Case Number:</b>	CM15-0109108		
<b>Date Assigned:</b>	06/15/2015	<b>Date of Injury:</b>	07/31/2001
<b>Decision Date:</b>	07/15/2015	<b>UR Denial Date:</b>	05/20/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	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: California

Certification(s)/Specialty: Internal Medicine

### 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 is a 58-year-old male, who sustained an industrial injury on 07/31/2001. He has reported injury to the neck and left upper extremity. The diagnoses have included cervical radiculopathy; status post cervical fusion, C6-7; left shoulder impingement; and right knee internal derangement. Treatment to date has included medications, diagnostics, physical therapy, injections, and surgical intervention. Medications have included Norco, Soma, Cyclobenzaprine, and Prilosec. A progress note from the treating physician, dated 04/15/2015, documented a follow-up visit with the injured worker. Currently, the injured worker complains of increased headaches and increased shoulder pain; neck and bilateral shoulder pain; intermittent mid back muscle spasms; left arm is getting worse; left shoulder pain is worse, and rated 8/10 on the visual analog scale; neck pain is radiating to the left arm, and rated at 6-7/10; pain is decreased by 50% and he is more functional with medications; the last injection to the left shoulder is still working; and physical therapy is helping. Objective findings included cervical spine reveals present spasm; range of motion is painful and decreased; decreased sensation on left C6 with pain across C6 distribution; neck spasm; decreased range of motion to the left; left shoulder with positive impingement; range of motion is painful; forward flexion and abduction are decreased; tenderness to palpation is positive over the acromioclavicular joint; and left arm has radicular pain. The treatment plan has included the request for Soma 350mg #30; Norco 10/325mg #120; and MRI cervical spine.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Soma 350mg #30:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 29.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47-49, Chronic Pain Treatment Guidelines Carisoprodol (Soma) Page 29. Muscle relaxants Page 63-65.

**Decision rationale:** Medical Treatment Utilization Schedule (MTUS) addresses muscle relaxants. American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) states that muscle relaxants seem no more effective than NSAIDs for treating patients with musculoskeletal problems, and using them in combination with NSAIDs has no demonstrated benefit. Muscle relaxants may hinder return to function by reducing the patient's motivation or ability to increase activity. Table 3-1 states that muscle relaxants are not recommended. Chronic Pain Medical Treatment Guidelines (Page 63-66) address muscle relaxants. Muscle relaxants should be used with caution as a second-line option for short-term treatment. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. According to a review in American Family Physician, muscle relaxants should not be the primary drug class of choice for musculoskeletal conditions. MTUS Chronic Pain Medical Treatment Guidelines state that Carisoprodol (Soma) is not recommended. This medication is not indicated for long-term use. The date of injury was 07-31-2001. The occupational injuries are chronic. The primary treating physician's progress reports dated 2/18/15 and 4/15/15 documented prescriptions for Soma. Medical records indicate the long-term use of Soma (Carisoprodol), which is not supported by MTUS guidelines. MTUS Chronic Pain Medical Treatment Guidelines state that Soma (Carisoprodol) is not recommended. MTUS and ACOEM guidelines do not support the use of Soma (Carisoprodol). Therefore, the request for Soma (Carisoprodol) is not medically necessary.

**Norco 10/325mg #120:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-96.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page 74-96. Hydrocodone/Acetaminophen Page 91.

**Decision rationale:** Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines (page 89) present the strategy for maintenance for long-term users of opioids. Do not attempt to lower the dose if it is working. Supplemental doses of break-through medication may be required for incidental pain, end-of dose pain, and pain that occurs with predictable situations. The standard increase in dose is 25 to 50% for mild pain and 50 to 100% for severe pain. Actual maximum safe dose will be patient-specific and dependent on current and previous opioid exposure, as well as on whether the patient is using such medications

chronically. Hydrocodone/Acetaminophen (Norco) is indicated for moderate to moderately severe pain. The date of injury was 07/31/2001. The patient is status post cervical fusion C6-7. The primary treating physician's progress report dated February 18, 2015 documented that examination of the cervical spine revealed spasm. Range of motion is painful and decreased. A healed anterior scar is noted. Decreased sensation on left C6. Pain across C6 distribution. Neck spasm was noted. Decreased range of motion to left was noted. Decreased rotation to the left was noted. The primary treating physician's progress report dated February 18, 2015 documented the results of the magnetic resonance imaging MRI of the cervical spine dated 1/20/15. MRI of the cervical spine report dated 1/20/15 revealed: (1) C3-C4: Bilateral neural foraminal narrowing secondary to 1-2 mm broad-based posterior disc protrusion and uncovertebral osteophyte formation. Bilateral exiting nerve root compromise is seen. (2) C4-C5: Bilateral neural foraminal narrowing, right greater than left, secondary to 1-2 mm broad-based posterior disc protrusion and uncovertebral osteophyte formation. Bilateral exiting nerve root compromise is seen. (3) C5-C6: Residual 2 mm broad-based posterior disc protrusion and uncovertebral osteophyte formation resulting in bilateral neural foraminal narrowing. Bilateral exiting nerve root compromise is seen. (4) C6-C7: Near-complete obliteration of the disc space is seen. This results in left neural foraminal narrowing. Left exiting nerve root compromise seen. Medical history included left shoulder impingement, and right knee internal derangement. MRI of left shoulder dated 1/21/15 revealed supraspinatus tendinosis, infraspinatus tendinosis, subscapularis tendinosis, and bicipital tenosynovitis. The primary treating physician's progress report dated April 15, 2015 documented that examination of the cervical spine revealed spasm. Range of motion is painful and decreased. A healed anterior scar is noted. Decreased sensation on left C6. Pain across C6 distribution. Neck spasm was noted. Decreased range of motion to left was noted. Decreased rotation to the left was noted. Medical records document objective physical examination findings. Medical records document regular physician clinical evaluations and monitoring. Per MTUS, Hydrocodone / Acetaminophen (Norco) is indicated for moderate to moderately severe pain. The request for Norco (Hydrocodone/Acetaminophen) is supported by the MTUS guidelines. Therefore, the request for Norco 10/325 mg is medically necessary.

**MRI Cervical Spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179, 181-183.

**Decision rationale:** Medical Treatment Utilization Schedule (MTUS) addresses cervical spine MRI magnetic resonance imaging. American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) Chapter 8 Neck and Upper Back Complaints states that reliance on imaging studies alone to evaluate the source of neck or upper back symptoms carries a significant risk of diagnostic confusion (false-positive test results). Table 8-8 Summary of Recommendations for Evaluating and Managing Neck and Upper Back Complaints (Page 181-183) states that radiography are the initial studies when red flags for fracture, or neurologic deficit associated with acute trauma, tumor, or infection are present. MRI may be recommended to evaluate red-flag diagnoses. Imaging is not recommended in the absence of red flags. MRI

may be recommended to validate diagnosis of nerve root compromise, based on clear history and physical examination findings, in preparation for invasive procedure. The date of injury was 07/31/2001. The patient is status post cervical fusion C6-7. The primary treating physician's progress report dated February 18, 2015 documented that examination of the cervical spine revealed spasm. Range of motion is painful and decreased. A healed anterior scar is noted. Decreased sensation on left C6. Pain across C6 distribution. Neck spasm was noted. Decreased range of motion to left was noted. Decreased rotation to the left was noted. The primary treating physician's progress report dated April 15, 2015 documented that examination of the cervical spine revealed spasm. Range of motion is painful and decreased. A healed anterior scar is noted. Decreased sensation on left C6. Pain across C6 distribution. Neck spasm was noted. Decreased range of motion to left was noted. Decreased rotation to the left was noted. The primary treating physician's progress report dated February 18, 2015 documented the the results of the magnetic resonance imaging MRI of the cervical spine dated 1/20/15. MRI of the cervical spine report dated 1/20/15 revealed: (1) C3-C4: Bilateral neural foraminal narrowing secondary to 1-2 mm broad-based posterior disc protrusion and uncovertebral osteophyte Formation. Bilateral exiting nerve root compromise is seen. (2) C4-C5: Bilateral neural Foraminal narrowing, right greater than left, secondary to 1-2 mm broad-based posterior disc protrusion and uncovertebral osteophyte formation. Bilateral exiting nerve root compromise is seen. (3) C5-C6: Residual 2 mm broad-based posterior disc protrusion and uncovertebral osteophyte formation resulting in bilateral neural foraminal narrowing. Bilateral exiting nerve root compromise is seen. (4) C6-C7: Near-complete obliteration of the disc space is seen. This results in left neural foraminal narrowing. Left exiting nerve root compromise seen. According to the 2/18/15 and 4/15/15 progress reports, the cervical spine physical examination was unchanged. No new cervical spine injuries were reported. The medical necessity of the request for a repeat MRI of the cervical spine was not established. Therefore, the request for repeat MRI of cervical spine is not medically necessary.