

<b>Case Number:</b>	CM15-0021460		
<b>Date Assigned:</b>	02/11/2015	<b>Date of Injury:</b>	09/14/2000
<b>Decision Date:</b>	03/27/2015	<b>UR Denial Date:</b>	01/28/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/04/2015

### 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: Iowa, Illinois, Hawaii

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & Gen Prev Med

### 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 55 year old female, who sustained an industrial injury on 9/14/2000. The details regarding the initial injury were not available for this review. The diagnoses have included lumbar disc displacement without myelopathy, lumbar radiculopathy, and lumbar degenerative disc disease. Treatment to date has included Non-Steroidal Anti-Inflammatory Drugs (NSAIDs), muscle relaxer, epidural steroid injections, and physical therapy. Currently, the IW complains of chronic back pain with leg pain associated with numbness, tingling, and weakness. On 1/16/15, the physical examination documented tenderness L3, and L4-L5 right side, decreased lumbar sacral Range of Motion (ROM), and positive straight leg raise test on the right. The plan of care included continuation of previously prescribed medication, physical therapy, and epidural injections. On 1/28/2015 Utilization Review non-certified a right L3-4 and L4-5 transforaminal epidural steroid injection, Soma 350mg #60, and Norco 10/325mg #180, noting the lack of documented functional improvement with the requested treatments. The MTUS Guidelines were cited. On 2/4/2015, the injured worker submitted an application for IMR for review of right L3-4 and L4-5 transforaminal epidural steroid injection, Soma 350mg #60, and Norco 10/325mg #180.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Right L3-4 and L4-5 TFESI:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287-315, Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs) Page(s): 46. Decision based on Non-MTUS Citation Low Back - Lumbar & Thoracic (Acute & Chronic), Epidural steroid injections (ESIs), therapeutic

**Decision rationale:** MTUS Chronic pain medical treatment guidelines state that epidural steroid injections are "Recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy) . . . Epidural steroid injection can offer short term pain relief and use should be in conjunction with other rehab efforts, including continuing a home exercise program." There were no medical documents provided to conclude that other rehab efforts or home exercise program is ongoing. Additionally, no objective findings were documented to specify the dermatomal distribution of pain. MTUS further defines the criteria for epidural steroid injections to include: 1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). 3) Injections should be performed using fluoroscopy (live x-ray) for guidance. 4) If used for diagnostic purposes, a maximum of two injections should be performed. A second block is not recommended if there is inadequate response to the first block. Diagnostic blocks should be at an interval of at least one to two weeks between injections. 5) No more than two nerve root levels should be injected using transforaminal blocks. 6) No more than one interlaminar level should be injected at one session. 7) In the therapeutic phase, repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year. (Manchikanti, 2003) (CMS, 2004) (Boswell, 2007) 8) Current research does not support a 'series-of-three' injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections. Medical documentation indicates this patient has had at least 3 previous ESIs, most recently in 8/2014. The treating physician documented minimal pain relief and no objective functional improvement was documented. Guidelines recommend against repeat injections without at least 50% documented pain relief and reduction of medication use of six to eight weeks as well as functional improvement. As such, the request for Right L3-4 and L4-5 TFESI is not medically necessary.

**Soma 350 MG #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol (Soma) and Muscle relaxants (for pain) Page(s): 29, 63-66. Decision based on Non-MTUS Citation Chronic Pain, Soma (Carisoprodol)

**Decision rationale:** MTUS states regarding Carisoprodol, "Not recommended. This medication is not indicated for long-term use. Carisoprodol is a commonly prescribed, centrally acting skeletal muscle relaxant whose primary active metabolite is meprobamate (a schedule-IV controlled substance). Carisoprodol is now scheduled in several states but not on a federal level. It has been suggested that the main effect is due to generalized sedation and treatment of anxiety. Abuse has been noted for sedative and relaxant effects. In regular abusers the main concern is the accumulation of meprobamate. Carisoprodol abuse has also been noted in order to augment or alter effects of other drugs." ODG States that Soma is "Not recommended. This medication is FDA-approved for symptomatic relief of discomfort associated with acute pain in musculoskeletal conditions as an adjunct to rest and physical therapy (AHFS, 2008). This medication is not indicated for long-term use." "The patient has been on the medication since at least 1/2013. TGuidelines do not recommend long term usage of SOMA. Treating physician does not detail circumstances that would warrant extended usage. As such, the request for Soma 350 MG #60 is not medically necessary.

**Norco 10/325 MG #180:** Upheld

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

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

**Decision rationale:** ODG does not recommend the use of opioids for low back pain "except for short use for severe cases, not to exceed 2 weeks." The patient has exceeded the 2 week recommended treatment length for opioid usage. MTUS does not discourage use of opioids past 2 weeks, but does state that "ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. 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 treating physician does not fully document the least reported pain over the period since last assessment, intensity of pain after taking opioid, pain relief, increased level of function, or improved quality of life. Additionally, medical documents indicate that the patient has been on Norco in excess of the recommended 2-week limit. As such, the request for Norco 10/325 MG #180 is not medically necessary.