

Case Number:	CM15-0049294		
Date Assigned:	03/18/2015	Date of Injury:	09/25/2003
Decision Date:	05/01/2015	UR Denial Date:	02/10/2015
Priority:	Standard	Application Received:	03/16/2015

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: Physical Medicine & Rehabilitation

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 60-year-old male, who sustained an industrial injury on 9/25/2003. He reported a fall from 5-6 feet from ladder onto a metal chair, injuring his neck and low back. The injured worker was diagnosed as having lumbar and cervical disc displacement without myelopathy, status post cervical laminectomy syndrome, lumbar and cervical degenerative disc disease, spinal stenosis, lumbago and thoracic and lumbosacral neuritis or radiculitis. There is no record of a recent diagnostic study. Treatment to date has included surgery, radio-frequency ablation, TENS (transcutaneous electrical nerve stimulation) and medication management. Currently, the injured worker complains of neck, shoulder and low back pain. In a progress note dated 1/5/2015, the treating physician is requesting Fentanyl, Soma and Prilosec.

IMR ISSUES, DECISIONS AND RATIONALES

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

Fentanyl 25mcg patch #10: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 9, 44, 47, 74, 78-97.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Fentanyl Transdermal (Duragesic) Criteria for Use of Opioids Page(s): 44, 76-78, 88-89.

Decision rationale: Based on the 01/05/15 progress report provided by treating physician, the patient presents with low back pain that radiates down bilateral lower extremities. The request is for FENTANYL 25MCG PATCH #10. RFA not provided. Patient's diagnosis on 01/05/15 includes cervical post-laminectomy syndrome, displacement of cervical intervertebral disc without myelopathy, displacement of lumbar intervertebral disc without myelopathy, disorder of trunk, and disorder of back. Patient is status post lumbar medial branch block 09/11/13 and lumbar radio frequency ablation on 10/28/14. Treatment to date has included surgery, radio-frequency ablation, TENS (transcutaneous electrical nerve stimulation) and medication management. Patient's medications include Norco, Fentanyl patch, Carisoprodol, Omeprazole, and Senokot. The patient has joined a gym and is attending 4-5 times per week. The patient is to remain off-work, per provider report dated 01/05/15. MTUS guidelines page 44 recommends Fentanyl transdermal (Duragesic) for management of persistent chronic pain, which is moderate to severe requiring continuous, around-the-clock opioid therapy. MTUS Guidelines pages 88 and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4A's (analgesia, ADLs, adverse side effects, and adverse behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. Fentanyl has been included in patient's prescriptions, per provider reports dated 06/27/14, 11/13/14, and 01/05/15. UR letter dated 02/10/15 modified request to Fentanyl #5. Per progress report dated 01/05/15, treater states that Fentanyl patch "continues to provide functional gains in significantly assisting [the patient's] ADL's as well as his mobility and restorative sleep... He reports medication reduces his pain by over 30%... Medication side effects are GI upset and constipation. Side effects well addressed with Omeprazole and laxative... Patient has signed pain management agreement with our practice. We routinely perform random urine drug testing to monitor compliance... CURES database to screen for multiple prescribers... No evidence of impairment of abuse. UDT's consistent with prescriptions... he does not take Soma generally when he has an appointment here because he drives 150 miles each way." In this case, the 4A's have been addressed, adequate documentation has been provided including numeric scales and functional measures that show significant improvement. Therefore, this request is medically necessary.

Soma 350 #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63-66.

Decision rationale: Based on the 01/05/15 progress report provided by treating physician, the patient presents with low back pain that radiates down bilateral lower extremities. The request is for SOMA 350 #30. RFA not provided. Patient's diagnosis on 01/05/15 includes cervical

post-laminectomy syndrome, displacement of cervical intervertebral disc without myelopathy, displacement of lumbar intervertebral disc without myelopathy, disorder of trunk, and disorder of back. Patient is status post lumbar medial branch block 09/11/13 and lumbar radio frequency ablation on 10/28/14. Treatment to date has included surgery, radio-frequency ablation, TENS (transcutaneous electrical nerve stimulation) and medication management. Patient's medications include Norco, Fentanyl patch, Carisoprodol, Omeprazole, and Senokot. The patient has joined a gym and is attending 4-5 times per week. The patient is to remain off-work, per treater report dated 01/05/15. MTUS, Chronic Pain Medication Guidelines, Muscle Relaxants, page 63-66: "Carisoprodol (Soma, Soprodon 350, Vanadom, generic available): Neither of these formulations is recommended for longer than a 2 to 3 week period." Abuse has been noted for sedative and relaxant effects... Muscle relaxants (for pain): Recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbation in patients with chronic LBP. The most commonly prescribed antispasmodic agents are carisoprodol, cyclobenzaprine, metaxalone, and methocarbamol, but despite their popularity, skeletal muscle relaxants should not be the primary drug class of choice for musculoskeletal conditions. Cyclobenzaprine (Flexeril, Amrix, Fexmid, generic available): Recommended for a short course of therapy. Carisoprodol has been included in patient's prescriptions, per provider reports dated 10/15/14, and 01/05/15. Per progress report dated 01/05/15, provider states the patient "does not take Soma generally when he has an appointment here because he drives 150 miles each way." The provider has documented functional benefit of this medication. However, MTUS only recommends short-term use (no more than 2-3 weeks) for sedating muscle relaxants. The patient has been prescribed Carisoprodol (Soma) from at least 10/15/14, which is almost 4 months from UR date of 02/10/15. Therefore, the request is not medically necessary.

Prilosec 20mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Non-Steroidal Anti-Inflammatory drugs (NSAIDs) Gastrointestinal (GI) Symptoms and Cardiovascular Risk Page(s): 68-69.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Against both GI and Cardiovascular Risk Page(s): 69.

Decision rationale: Based on the 01/05/15 progress report provided by treating physician, the patient presents with low back pain that radiates down bilateral lower extremities. The request is for PRILOSEC 20MG #30. RFA not provided. Patient's diagnosis on 01/05/15 includes cervical post-laminectomy syndrome, displacement of cervical intervertebral disc without myelopathy, displacement of lumbar intervertebral disc without myelopathy, disorder of trunk, and disorder of back. Patient is status post lumbar medial branch block 09/11/13 and lumbar radio frequency ablation on 10/28/14. Treatment to date has included surgery, radio-frequency ablation, TENS (transcutaneous electrical nerve stimulation) and medication management. Patient's medications include Norco, Fentanyl patch, Carisoprodol, Omeprazole, and Senokot. The patient has joined a gym and is attending 4-5 times per week. The patient is to remain off-work, per provider report dated 01/05/15. MTUS pg 69 states, "Clinicians should weight the indications for NSAIDs against both GI and cardiovascular risk factors. Determine if the patient is at risk for gastrointestinal events: (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA)." "Treatment of dyspepsia secondary to NSAID therapy:

Stop the NSAID, switch to a different NSAID, or consider H2-receptor antagonists or a PPI." Omeprazole has been included in patient's prescriptions, per provider reports dated 06/27/14, 11/13/14, and 01/05/15. Per progress report dated 01/05/15, provider states medication side effects due to Fentanyl are GI upset and constipation, and that side effects well addressed with Omeprazole and laxative. Patient's medications do not include NSAIDs in list of prescriptions. The patient is not on NSAID therapy, to warrant prophylactic use of Omeprazole, based on guidelines. Therefore, the request is not medically necessary.