

<b>Case Number:</b>	CM14-0182851		
<b>Date Assigned:</b>	11/07/2014	<b>Date of Injury:</b>	05/12/2011
<b>Decision Date:</b>	12/11/2014	<b>UR Denial Date:</b>	10/13/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/03/2014

### 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 Interventional Spine and is licensed to practice in California. 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 49 year old female with an injury date on 05/12/2011. Based on the 09/22/2014 progress report provided by [REDACTED] the diagnoses are: 1. C4-C5 and C5-C6 spondylosis with anterior and posterior disc osteophyte complexes; 2. Status post anterior posterior fusion at L4 through S1 with right lower extremity radiculopathy. According to this report, the patient complains of "constant postoperative low back pain, with radiation to the right lower extremity." Physical exam reveals positive straight leg raise on the right and decreased sensation to light touch on the posterior calf. The 05/30/2014 report indicates the patient "rates a 5 on the pain scale with radiation in to the bilateral lower extremities with numbness, tingling, and paresthesias." Tenderness is noted over the lumbar paravertebral musculature. Lumbar range of motion is limited. Straight leg raise is positive on the left. Decreased motor strength and sensation of the left lower extremity are noted. Patella and Achilles tendon reflexes on the left are decreased. The patient is using a walker for ambulation. There were no other significant findings noted on this report. The utilization review denied the request on 10/13/2014. [REDACTED] [REDACTED] is the requesting provider and he provided treatment reports from 04/01/2014 to 09/22/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**1 Prescription for Medrol Dosepak #1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Methylprednisolone, Pain Chapter, online for: Oral corticosteroids

**Decision rationale:** According to the 09/22/2014 report by [REDACTED] this patient presents with "constant postoperative low back pain, with radiation to the right lower extremity." The treating physician is requesting Medrol dosepak #1. Regarding Methylprednisolone, ODG states "Not recommended for chronic pain. There is no data on the efficacy and safety of systemic corticosteroids in chronic pain, so given their serious adverse effects, they should be avoided. (Turner, 2012) See the Low Back Chapter, where they are recommended in limited circumstances for acute radicular pain. Multiple severe adverse effects have been associated with systemic steroid use, and this is more likely to occur after long-term use. And Medrol (methylprednisolone) tablets are not approved for pain. (FDA, 2013)." In this case, the patient does not present with an "acute radicular pain" to warrants the use of this medication; therefore, recommendation is that the request is not medically necessary.

**1 Prescription for Norco 10/325mg tablet #90: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medications for chronic pain, Criteria for Use of Opioids Page(s): 60, 61, 88, 89, 76-78.

**Decision rationale:** According to the 09/22/2014 report by [REDACTED] this patient presents with "constant postoperative low back pain, with radiation to the right lower extremity." The treating physician is requesting 1 Prescription for Norco 10/325mg tablet #90. Norco was first mentioned in the 08/29/2014 report; it is unknown exactly when the patient initially started taking this medication. For chronic opiate use, 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 4As (analgesia, ADLs, adverse side effects, and aberrant 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. Per 05/30/2014 report, patient "rates a 5 on the pain scale with radiation in to the bilateral lower extremities with numbness, tingling and paresthesias. The pain is affecting her activities of daily living and functional capacity. "A urine toxicology report on 08/24/2014 was provided for review. In this case, the report shows documentation of pain assessment using a numerical scale describing the patient's pain and a general statement regarding ADL's. Urine toxicology report was mentioned. However, there is no demonstration of "significant" improvement in ADL's. The treating physician does not mention in what specific way the ADL's or functions are improved. There is no return to work or work status change with use of medication; no specific activities such as exercises, house-work, social interactions are discussed showing significant improvement due to

medication use. The documentation also lack discussion regarding side effects, other opiates management issues such as CURES, and behavioral issues. Given the lack of sufficient documentation demonstrating efficacy from chronic opiate use, the patient should be slowly weaned as outlined in MTUS Guidelines. Recommendation is that the request is not medically necessary.

**1 Prescription for Soma 350mg tablet #90: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chapter 8 Neck and Upper Back Complaints, Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 63, 64.

**Decision rationale:** According to the 09/22/2014 report by [REDACTED] this patient presents with "constant postoperative low back pain, with radiation to the right lower extremity." The treating physician is requesting 1 Prescription for Soma 350mg tablet #90. For muscle relaxants for pain, the MTUS Guidelines page 63 state "Recommended non-sedating muscle relaxants with caution as a second line option for short term treatment of acute exacerbation in patients with chronic LBP. Muscle relaxants may be effective in reducing pain and muscle tension and increasing mobility; however, in most LBP cases, they showed no benefit beyond NSAIDs and pain and overall improvement." A short course of muscle relaxant may be warranted for patient's reduction of pain and muscle spasms. However, the treating physician is requesting Soma #90; the patient has been on Soma since 08/20/2014. Soma is not recommended for long term use. The treating physician does not mention that this is for a short-term use. Recommendation is that the request is not medically necessary.