

<b>Case Number:</b>	CM15-0113234		
<b>Date Assigned:</b>	06/24/2015	<b>Date of Injury:</b>	09/25/2001
<b>Decision Date:</b>	08/20/2015	<b>UR Denial Date:</b>	05/14/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/11/2015

### 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, Tennessee

Certification(s)/Specialty: Emergency 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 63 year old female, who sustained an industrial injury on 9/25/01. She reported pain in her lower back and left knee. The injured worker was diagnosed as having lumbago and pain in lower leg joint. Treatment to date has included a left knee intraarticular injection on 2/17/15 with benefit and physical therapy. Current medications include Anaprox, Norco and Soma since at least 11/17/14. On 1/20/15, the injured worker reported moderate to severe low back pain. Subsequent progress notes focus on left knee treatment and examination. As of the PR2 dated 5/8/15, the injured worker reports pain in her left knee. Objective findings include swelling over left knee, limited range of motion and severe tenderness on medial side along joint line. The treating physician requested Anaprox 500mg #120, Norco 10/325mg #120, Soma 350mg #90 and a lumbar MRI.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Anaprox 500mg #120:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Guidelines Page(s): 67-68.

**Decision rationale:** Anaprox is naproxen, a non-steroidal anti-inflammatory drug (NSAID). Chronic Medical Treatment Guidelines state that anti-inflammatory drugs are the traditional first line of treatment, but long term use may not be warranted. For osteoarthritis it was recommended that the lowest dose for the shortest length of time be used. It was not shown to be more effective than acetaminophen, and had more adverse side effects. Adverse effects for GI toxicity and renal function have been reported. Medications for chronic pain usually provide temporary relief. Medications should be prescribed only one at a time and should show effect within 1-3 days. Record of pain and function with the medication should be documented. In this case the patient had been receiving Anaprox since November 2014 without relief. The duration of treatment increases the risk of adverse effects with little benefit. The request should not be authorized.

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

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Guidelines Page(s): 11, 74-96.

**Decision rationale:** Norco is the compounded medication containing hydrocodone and acetaminophen. Chronic Pain Medical Treatment Guidelines state that opioids are not recommended as a first line therapy. Opioid should be part of a treatment plan specific for the patient and should follow criteria for use. Criteria for use include establishment of a treatment plan, determination if pain is nociceptive or neuropathic, failure of pain relief with non-opioid analgesics, setting of specific functional goals, and opioid contract with agreement for random drug testing. If analgesia is not obtained, opioids should be discontinued. The patient should be screened for likelihood that he or she could be weaned from the opioids if there is no improvement in pain or function. It is recommended for short term use if first-line options, such as acetaminophen or NSAIDs have failed. Opioids may be a safer choice for patients with cardiac and renal disease than antidepressants or anticonvulsants. Acetaminophen is recommended for treatment of chronic pain & acute exacerbations of chronic pain. Acetaminophen overdose is a well-known cause of acute liver failure. Hepatotoxicity from therapeutic doses is unusual. Renal insufficiency occurs in 1 to 2% of patients with overdose. The recommended dose for mild to moderate pain is 650 to 1000 mg orally every 4 hours with a maximum of 4 g/day. In this case the patient has been receiving Norco since at least November 2014 and has not obtained analgesia. In addition there is no documentation that the patient has signed an opioid contract or is participating in urine drug testing. Criteria for long-term opioid use have not been met. The request should not be authorized.

**Soma 350mg #90:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Guidelines Page(s): 29.

**Decision rationale:** Soma is the muscle relaxant carisoprodol. Carisoprodol is not recommended. Carisoprodol is a commonly prescribed, centrally acting skeletal muscle relaxant whose primary active metabolite is meprobamate (a schedule-IV controlled substance). Abuse has been noted for sedative and relaxant effects. Carisoprodol abuse has also been noted in order to augment or alter effects of other drugs. These drugs include cocaine, tramadol, hydrocodone, benzodiazepines, and alcohol. A withdrawal syndrome has been documented that consists of insomnia, vomiting, tremors, muscle twitching, anxiety, and ataxia when abrupt discontinuation of large doses occurs. The patient has been using Soma since at least April 2015 with no benefit. The request should not be authorized.

**MRI lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back Chapter.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar and Thoracic MRIs and Other Medical Treatment Guidelines MRI lumbar spine.

**Decision rationale:** MRI of the spine is recommended for indications below. MRIs are test of choice for patients with prior back surgery. MRI of the lumbar spine for uncomplicated low back pain, with radiculopathy, is not recommended until after at least one month conservative therapy, sooner if severe or progressive neurologic deficit. Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (eg, tumor, infection, fracture, neurocompression, recurrent disc herniation). Indications for imaging - Magnetic resonance imaging: Thoracic spine trauma: with neurological deficit; Lumbar spine trauma: trauma, neurological deficit; Lumbar spine trauma: seat belt (chance) fracture (if focal, radicular findings or other neurologic deficit); Uncomplicated low back pain, suspicion of cancer, infection, other "red flags;" Uncomplicated low back pain, with radiculopathy, after at least 1 month conservative therapy, sooner if severe or progressive neurologic deficit; Uncomplicated low back pain, prior lumbar surgery; Uncomplicated low back pain, cauda equina syndrome; Myelopathy (neurological deficit related to the spinal cord), traumatic; Myelopathy, painful; Myelopathy, sudden onset; Myelopathy, stepwise progressive; Myelopathy, slowly progressive; Myelopathy, infectious disease patient; Myelopathy, oncology patient In this case there is no documentation that the patient is experiencing neurological deficits and there are no red flags. Indication for MRI of the lumbar spine is not supported by the documentation in the medical record. The request should not be authorized.