

Case Number:	CM15-0078915		
Date Assigned:	04/30/2015	Date of Injury:	09/20/2005
Decision Date:	06/25/2015	UR Denial Date:	03/24/2015
Priority:	Standard	Application Received:	04/24/2015

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

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 41 year old male who sustained an industrial injury to his lower back on 09/20/2005. The injured worker was diagnosed with lumbar degenerative disc disease. Treatment to date includes diagnostic testing, surgery, psychological support and counseling and medications. The injured worker is status post L4-L5 laminectomy and discectomy in December 2005 and posterior lumbar surgery on January 15, 2014. According to the primary treating physician's progress report on March 9, 2015, the injured worker continues to experience low back pain with episodes of right lower extremity pain. Examination of the lumbar spine demonstrated decreased range of motion with tenderness at the mid line of the lower lumbar spine. Gait was antalgic. Lower extremities had decreased motor strength of all muscle groups. Sensation of the right lower extremity was normal with reduced sensation to light touch along the anterolateral left thigh and lateral posterior left leg. Straight leg raise test was positive bilaterally. Current medications are listed as Ativan, Celebrex, Lyrica, Soma, Suboxone, Trazodone, Percocet and Phentermine. Treatment plan consists of laboratory blood tests, transcutaneous electrical nerve stimulation (TEN's) unit; continue therapy with psychologist and the current request for renewal medications of Ativan, Lyrica, Suboxone and Soma.

IMR ISSUES, DECISIONS AND RATIONALES

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

Soma 350mg by mouth 4 times a day, #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol (Soma); Muscle relaxants (for pain).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 29, 63.

Decision rationale: The CA MTUS does not recommend muscle relaxants for chronic pain. Non-sedating muscle relaxants are an option for short-term exacerbations of chronic low back pain. Soma (Carisoprodol) is the muscle relaxant requested in this case. This medication is sedating. No reports show any specific and significant improvements in pain or function as a result of prescribing muscle relaxants. According to the MTUS guidelines, Soma is categorically not recommended for chronic pain, noting its habituating and abuse potential. Medical necessity for the requested medication has not been established. The requested medication is not medically necessary.

Lyrica 50mg, 1 tablet by mouth every morning and 2 tablets by mouth every night, #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Specific Anti-Epilepsy Drugs - Pregabalin (Lyrica, no generic available).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lyrica Page(s): 58.

Decision rationale: According to California MTUS Guidelines, anti-epilepsy medications are a first-line treatment for neuropathic pain. Lyrica is FDA approved for diabetic neuropathy and post-herpetic neuralgia and has been used effectively for the treatment of other neuropathic pain. A good response to therapy with this medication is described as a 50% reduction in complaints of neuropathic pain. In this case, this patient has low back pain (LBP) without documentation of neuropathic pain. Lyrica has been used in the past. However, there is no documentation that guidelines have been met. Medical necessity for the requested medication has not been established. The requested item is not medically necessary.

Ativan 1mg by mouth 2 times a day, #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24. Decision based on Non-MTUS Citation Official Disability Guidelines: Benzodiazepines.

Decision rationale: According to CA MTUS Guidelines, benzodiazepines are prescribed for anxiety. They are not recommended for long-term use for the treatment of chronic pain because

long-term efficacy is unproven and there is a risk of dependency. Ativan (Lorazepam) is an intermediate acting benzodiazepine, having anxiolytic, sedative, and hypnotic properties. Most guidelines recommend the use of Ativan for the treatment of anxiety disorders, and as an adjunct treatment for anxiety associated with major depression. Use of this medication is limited to four weeks. There is no documentation provided indicating that the patient is maintained on any antidepressant medication. In addition, there are no guideline criteria that supports the long-term use of benzodiazepines. Medical necessity for the requested medication has not been established. The requested medication is not medically necessary.

Suboxone 8/2mg 1 tablet dissolved under tongue 4 times a day or 3 times a day, #100:
Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for the treatment of chronic pain Page(s): 91-97. Decision based on Non-MTUS Citation Opioids for the treatment of chronic pain.

Decision rationale: Buprenorphine is a semi-synthetic opioid derivative of thebaine. It is a mixed agonist antagonist opioid receptor modulator that is used to treat opioid addiction in higher dosages, to control moderate acute pain in non-opioid-tolerant individuals in lower dosages and to control moderate chronic pain in even smaller doses. The treatment of chronic pain with any opioid analgesic requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. A pain assessment should include current pain, intensity of pain after taking the opiate, and the duration of pain relief. In this case, there is no documentation of the medication's pain relief effectiveness, functional status, or response to ongoing opioid analgesic therapy. Medical necessity of the requested item has not been established. Of note, discontinuation of an opioid analgesic should include a taper, to avoid withdrawal symptoms. Medical necessity for the requested medication is not established. The requested medication is not medically necessary.