

Case Number:	CM13-0045524		
Date Assigned:	12/27/2013	Date of Injury:	06/30/2009
Decision Date:	03/25/2015	UR Denial Date:	10/09/2013
Priority:	Standard	Application Received:	11/12/2013

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 Mexico, California, Texas
 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 claimant had an injury in Nov 2005 which was treated with microdiscectomy and hemilaminectomy at L4-L5 level in Feb 2006. The original injury involved landing from a height of 6 feet onto his legs with jarring and pain of the lower back. Subsequently, patient worked with restrictions that he claims were not followed when he started working for ██████████ in 2/1/2007. He was terminated in 2009 and has been unemployed since. He was seen by an orthopedic specialist from 1/2010 through the end of 2011. During that time, he was treated with oral naproxen, hydrocodone, Ultracet and tizanidine. He received four epidural injections with steroids during that time. He continued to complain of intolerable pain during those two years and had filed a second claim against Pristine Tile. He was subsequently seen by a different spine and orthopedics physician in Mar 2012. At that time, the physician noted that the patient had a history of anxiety. The claimant had an MRI dated 4/23/2012 showing multilevel disk degeneration with minimal protrusion and no thecal impingement. He had L5-S1 foraminal narrowing, left more than right, with compression of nerve roots. He also had moderate lumbar spinal stenosis at L3-L4. A nerve conduction study / electromyogram was accomplished on 10/10/2011 demonstrating a chronic but mild left L5 lumbar radiculopathy. The patient's examination on 9/12/2013 revealed paraspinal muscle spasm and positive straight leg raising test at 45%. There were also subtle sensory abnormalities in the L5 distribution on the left. The claimant had been treated with naproxen, Flexeril, Neurontin and Ultracet from 3/2012 onwards but on 8/1/2013 and 9/12/2013, only Prilosec, Flexeril and Ultracet were prescribed. The

claimant is awaiting lumbar spine surgery with L3-S1 posterior and anterior fixation with fusion per the recommendation of his current orthopedic surgeon.

IMR ISSUES, DECISIONS AND RATIONALES

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

ULTRACET #180: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78, 84.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 110-114.

Decision rationale: Per the MTUS guidelines, 2009, opioid use for chronic pain includes several elements during on-going use to justify such use AND to make it appropriate / safe. As listed on Pg 78 of the MTUS document, if a patient fails to obtain adequate pain relief within three months of initiation of opioid therapy, referral to a specialized pain clinic is recommended. According to the documentation provided, the attending surgeon documents a failure to control pain on opioids and lack of relief from pain in multiple notations throughout the chart. Second, according to the MTUS document referenced above, prior to initiation of opioid therapy, an attempt should be made to determine if the pain is nociceptive or neuropathic or both. Opioids are not first line of therapy for some forms of neuropathic pain. According to the same document, several other classes of medications can be employed for management of neuropathic pain including tricyclic antidepressants, duloxetine, anti-epileptics such as gabapentin, lamotrigine, pregabalin and topiramate. Serotonin and norepinephrine reuptake inhibitors are also effective in neuropathic pain. The claimant is currently not on an agent specific for management of neuropathic pain at an adequate dose. Third, the claimant has a history of anxiety, as documented by the orthopedic surgeon in the visit of 3/2012 and opioid initiation in patients with anxiety or other behavioral problems should involve psychological assessment according to the MTUS. According to the MTUS, baseline pain and functional assessment should be done with standardized and validated instruments. These should be monitored over time to determine the efficacy. Regular and ongoing assessment of the need for non-opioid therapies is recommended. This includes physical therapy, biofeedback, local therapies such as capsaicin and lidocaine as well as other non-opioid therapies appropriate for neuropathic pain, as detailed previously. For all these reasons, ongoing Ultracet therapy does not appear to be justified. It has not been documented by the attending surgeon to produce any overall improvement in the claimant's condition over the course of use. Opportunities for other therapies and appropriate consultations exist that may allow achievement of better pain control and functional status. Exploring these is a part of appropriate chronic opioid therapy as stated explicitly in the MTUS document on the pages referenced above.