

<b>Case Number:</b>	CM13-0017511		
<b>Date Assigned:</b>	11/06/2013	<b>Date of Injury:</b>	10/10/2003
<b>Decision Date:</b>	01/17/2014	<b>UR Denial Date:</b>	08/19/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/28/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Anesthesiology, has a subspecialty in Pain Medicine 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 physician 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 reported an injury on 11/01/2003. The mechanism of injury was not provided for review. The patient had chronic low back pain radiating into the lower extremities. MRI revealed multilevel disc bulging. The patient's chronic pain was managed with medications to include Percocet, OxyContin, and Lidoderm patches. The patient was regularly monitored for aberrant behavior with urine drug screens. The patient underwent 2 facet injections that provided a decrease in pain levels. The patient's most recent clinical evaluation revealed pain complaints rated at 3/10, lumbar range of motion described as 60 degrees in flexion and 15 degrees in extension with 3/5 strength of the lower extremities. The patient's diagnoses included low back pain; displacement of lumbar intervertebral disc. The patient's treatment plan included continued medications and replacement of a TENS unit.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**TENS unit:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS unit Page(s): 114.

**Decision rationale:** The requested TENS unit is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient previously owned a TENS unit. However, California Medical Treatment Utilization Schedule does not recommend this treatment as a standalone treatment. The clinical documentation submitted for review does not provide evidence that the patient is participating in an active therapy program such as an independent home exercise program that would benefit from the addition of usage of a TENS unit. Additionally, the efficacy of the prior TENS unit is not provided within the documentation. As such, the requested TENS unit is not medically necessary or appropriate.

**Oxycontin 20mg #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 76.

**Decision rationale:** The requested prescription of Oxycontin 20 mg #60 is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient has chronic low back pain that radiates into her lower extremities and interferes with her activities of daily living. California Medical Treatment Utilization Schedule recommends the continued use of opioids in the management of a patient's chronic pain be supported by documentation of pain relief, functional benefit, side effects, and monitoring of aberrant behavior. The most recent clinical documentation submitted for review does not provide any evidence the patient has any functional benefit or pain relief from the prescribed medications. As such, the requested Oxycontin 20 mg #60 is not medically necessary or appropriate.

**Percocet 7.5/500 mg #180:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 76.

**Decision rationale:** The requested Percocet 7.5/500 mg #180 is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient does have chronic low back pain radiating into the lower extremities. California Medical Treatment Utilization Schedule recommends the ongoing use of opioids in the management of the patient's chronic pain be supported by documented pain relief, functional benefit, side effects, and monitoring for aberrant behavior. The clinical documentation submitted for review does not provide any evidence of pain relief or functional benefit as result of the patient's prescribed medications. As such, the requested Percocet 7.5/500 mg #180 is not medically necessary or appropriate.

**Lidoderm 5% #30 with 2 refills:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics and Medications for Chronic Pain Page(s): 111, 60.

**Decision rationale:** The requested Lidoderm patches 5% #30 with 2 refills is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient has used Lidoderm patches for an extended duration to control the patient's low back pain. California Medical Treatment Utilization Schedule recommends the continued use of this medication be supported by an assessment of pain relief and functional benefit. The clinical documentation submitted for review does not provide any evidence that the patient has any pain relief or functional benefit related to this medication. As such, the requested Lidoderm 5% #30 with 2 refills is not medically necessary or appropriate.