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| <b>Case Number:</b>   | CM13-0020065 |                              |            |
| <b>Date Assigned:</b> | 11/20/2013   | <b>Date of Injury:</b>       | 04/18/2012 |
| <b>Decision Date:</b> | 02/04/2014   | <b>UR Denial Date:</b>       | 08/15/2013 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 09/04/2013 |

### 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 Occupational 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 applicant is a represented 46-year-old who has filed a claim for chronic low back pain reportedly associated with industrial injury of April 18, 2012. Thus far, the applicant has been treated with the following: Analgesic medications; adjuvant medications; muscle relaxants; apparent diagnosis with complex regional pain syndrome (CRPS); antidepressant medications; and a spinal cord stimulator. In a Utilization Review Report of August 15, 2013, the claims administrator certified a retrial of a spinal cord stimulator, denied a request for Lyrica, denied a request for OxyContin, denied a request for Percocet, denied a request for Desyrel, and partially certified a request for Zanaflex. The applicant's attorney later appealed. A progress note of October 28, 2013 is notable for comments that the applicant has failed several conservative treatments. She is off of work, on total temporary disability. She states that she is very sedentary as a result of not having pain medications. She was on OxyContin and Percocet. It is stated that the applicant has failed physical therapy, sympathetic ganglion blocks, and a spinal cord stimulator trial. It is stated that the applicant's quality of life is significantly diminished as a result of not being provided analgesic medications. The applicant's prior usage of Lyrica requested in diminished right foot pain and improved ability to stand and walk. The applicant is placed off of work, on total temporary disability. It is stated throughout the report that the applicant is dependent on her oral medications, but does not want to take opioids for the rest of her life.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**. Request for 1 prescription of Lyrica 75 mg: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 99.

**Decision rationale:** The request for Lyrica 75 mg is medically necessary, medically appropriate, and indicated here. As noted on page 99 of the MTUS Chronic Pain Medical Treatment Guidelines, Lyrica is a first-line treatment for neuropathic pain. In this case, the attending provider has specifically stated that the applicant has demonstrated some strides and effected some functional improvement through prior usage of Lyrica. The applicant's ability to stand and walk has been reportedly diminished as a result of Lyrica usage. The applicant's right foot pain has also diminished as a result of Lyrica usage. Continuing the same is indicated and appropriate in this context. Therefore, the request is certified, on Independent Medical Review

**Request for 1 prescription of Oxycontin 20 mg: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 80.

**Decision rationale:** The request for OxyContin 20 mg, conversely, is not medically necessary, medically appropriate, or indicated here. As noted on the page 80 of the MTUS Chronic Pain Medical Treatment Guidelines, the cardinal criteria for continuation of opioid therapy include evidence of successful return to work, improved function and reduced pain affected as a result of ongoing usage of opioid usage. In this case, however, there is no evidence that the applicant meets the aforementioned criteria. There is no evidence that the applicant has returned to any form of work. She remains off of work, on total temporary disability. There is no clear evidence that she has effected any lasting benefit or functional improvement in terms of reduced pain and/or improved performance of nonwork activities of daily living through prior usage of OxyContin. Therefore, the request is likewise non-certified.

**Request for 1 prescription of Percocet 10/325 mg: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 80.

**Decision rationale:** Similarly, the request for Percocet 10/325 mg is also not medically necessary, medically appropriate, or indicated here. As with the OxyContin, there is no seeming

evidence that the applicant has returned to work. There is no evidence of any significant reduction in pain scores or improved performance of activities of daily living affected through prior Percocet usage. Therefore, the request is not certified.

**Request for 1 prescription of Trazodone 50 mg: Overturned**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 13.

**Decision rationale:** The request for trazodone 50 mg, conversely, is medically necessary, medically appropriate, and indicated here. As noted on Page 13 of the MTUS Chronic Pain Medical Treatment Guidelines, antidepressants are considered a first-line option for neuropathic pain and as a possibility for non-neuropathic pain. In this case, the applicant does seemingly have complaints of neuropathic pain secondary to chronic regional pain syndrome of lower extremity. Since antidepressants take some time to exert their maximal effect, on balance, continuing trazodone or Desyrel is a more appropriate option than discontinuing the same, although it does not appear clear that trazodone has been beneficial to date. Nevertheless, given the fairly lengthy amount of time that it takes for the antidepressants to take effect, the request is certified.

**Request for 1 prescription of Zanaflex 4 mg: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 66.

**Decision rationale:** The request for tizanidine or Zanaflex is not medically necessary, medically appropriate, or indicated here. As noted on page 66 of the MTUS Chronic Pain Medical Treatment Guidelines, tizanidine or Zanaflex is FDA approved in the management of spasticity and can be employed off label for treatment of low back pain. In this case, however, as with the many other opioid and non-opioid medications, there is no clear evidence of functional improvement as defined in MTUS 9792.20f through prior usage of tizanidine, which would justify its continued usage. The applicant has failed to return to work. There is no evidence of reduction in dependence on medical treatment. The applicant is now considering an intrathecal pump and a spinal cord stimulator trial. All of the above, taken together, suggests a lack of functional improvement as defined in section 9792.20f. Therefore, the request remains non-certified, on Independent Medical Review.