

<b>Case Number:</b>	CM13-0026751		
<b>Date Assigned:</b>	01/10/2014	<b>Date of Injury:</b>	01/06/1995
<b>Decision Date:</b>	07/30/2014	<b>UR Denial Date:</b>	09/13/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/19/2013

### 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. The expert reviewer is Board Certified in Occupational medicine and is licensed to practice in Texas. 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/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 injured worker is a 62 year old female who had a work related injury on 01/06/95 as a result of motor vehicle accident during work. The injured worker had five spinal surgeries including L3 to S1 fusion from 1996 until present. She reported her pain level was 5-8/10 has not changed any time over the past 15 years, with the exception of slight improvement which occurred during last bout of physical therapy, where she had aquatic therapy in conjunction with being treated by massage therapist. She currently rated her low back pain 8/10 and stated the lowest it got was 6/10 on a good day. She was only able to tolerate 10 minutes of sitting, five to ten minutes of standing and walking. She stated her pain radiated into bilateral lower extremities. Most recent note dated 11/19/13 injured worker reported 50% improvement in symptoms with the use of pool therapy. Physical examination, tenderness to palpation left lumbar spine, paraspinals, and bilateral sacroiliac joints right greater than left. Gait, she walked with a cane. Tenderness over left facets. Could not flex or extend without pain. Right sacroiliac joint pain. Diagnoses was lumbar radiculopathy. Insomnia, secondary to chronic pain. Opioid dependence. Myofascial pain. Failed back surgery. Sacroiliac joint dysfunction, right greater than left. Current request was for comprehensive urine drug screen mayo pain drug screen times one, transcutaneous electrical nerve stimulation unit, Nucynta ER 50mg #60, Dilaudid 40mg #120, Lyrica 100mg with one refill, Colace unspecified quantity, Celebrex 100mg unspecified quantity, Flexeril 10mg #90 with one refill, and Lidoderm patches unspecified quantity with five refills.

### IMR ISSUES, DECISIONS AND RATIONALES

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

## **COMPREHENSIVE UDS MAYO PAIN DRUG SCREEN X 1: Overturned**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Drug testing Page(s): 43. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Urine drug testing (UDT).

**Decision rationale:** The request for comprehensive urine drug screen Mayo pain drug screen x 1, is medically necessary. The clinical documentation and current evidence based guidelines do support the request. There is on going management at the present time. Therefore medical necessity has been established and as such is medically necessary.

**TENS: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, TENS, chronic pain (transcutaneous electrical nerve stimulation).

**Decision rationale:** The request for transcutaneous electrical nerve stimulation unit is not medically necessary. Not recommended as a primary treatment modality, but a one-month home-based transcutaneous electrical nerve stimulation trial may be considered as a noninvasive conservative option. Not recommended as an isolated intervention in low back pain. No clinical documentation submitted that the injured worker had a trial. As such, medical necessity has not been established and is therefore not medically necessary.

**NUCYNTA ER 50MG #60: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opiate's Page(s): 74-80. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Opioid's.

**Decision rationale:** The request for Nucynta ER 50mg # 60 is not medically necessary. The clinical documentation submitted for review as well as current evidence based guideline do not support the request. The injured workers pain scale is constantly 6-8 on visual analog scale. There is no documentation of functional improvement, as well as no urine drug screen submitted. Based on the clinical evidence submitted, medical necessity has not been established. However, these medications cannot be abruptly discontinued due to withdrawal symptoms, and

medications should only be changed by the prescribing physician. The request is not medically necessary.

**DILAUDID 4MG #120:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opiate's Page(s): 74-80. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, opioid's.

**Decision rationale:** The request for Dilaudid 4 mg #120 is not medically necessary. The clinical documentation submitted for review, as well as current evidence based guideline do not support the request. The injured workers pain scale is constantly 6-8 on visual analog scale. There is no documentation of functional improvement, as well as no urine drug screen submitted. Based on the clinical evidence submitted, medical necessity has not been established. However, these medications cannot be abruptly discontinued due to withdrawal symptoms, and medications should only be changed by the prescribing physician. The request is not medically necessary.

**LYRICA 100MG WITH 1 REFILL:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs (AEDs) Page(s): 16-17. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Anti-epilepsy drugs (AEDs) for pain.

**Decision rationale:** The request for Lyrica 100mg with 1 refill is not medically necessary. The clinical documentation submitted for review, as well as current evidence based guideline do not support the request. There is no clinical evidence that the injured worker is benefiting from this treatment. . The injured workers pain scale is constantly 6-8 on visual analog scale scale. There is no documentation of functional improvement. Therefore medical necessity has not been established and the request is therefore not medically necessary.

**COLACE-UNSPECIFIED STRENGTH AND QUANTITY:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Opioid-induced constipation.

**Decision rationale:** The request for Colace unspecified strength and quantity is not medically necessary. As such medical necessity has not been established. The clinical documentation submitted for review, as well as current evidence based guideline do not support the request and therefore the request is not medically necessary.

**CELEBREX 100MG UNSPECIFIED QUANTITY: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, NSAID.

**Decision rationale:** The request for Celebrex 100mg unspecified quantity is not medically necessary. The clinical documentation submitted for review, as well as current evidence based guideline do not support the request. There is no clinical evidence that the injured worker is benefiting from this treatment. . The injured workers pain scale is constantly 6-8 on visual analog scale scale. There is no documentation of functional improvement. Therefore the request is not medically necessary.

**FLEXERIL 10MG #90 WITH 1 REFILL: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Flexeril Page(s): 41. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Cyclobenzaprine (Flexeril).

**Decision rationale:** The request for Flexeril 10mg # 90 with 1 refill is not medically necessary. The clinical documentation submitted for review, as well as current evidence based guideline do not support the request. Recommended as an option, using a short course of therapy. Therefore, medical necessity has not been established and is therefore not medically necessary.

**LIDODERM PATCHES-UNSPECIFIED QUANTITY-5 REFILLS: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Lidoderm® (lidocaine patch).

**Decision rationale:** The request for Lidoderm patches unspecified quantity with 5 refills is not medically necessary. The clinical documentation submitted for review, as well as current evidence based guideline do not support the request. A Trial of patch treatment is recommended

for a short-term period (no more than four weeks). The area for treatment should be designated as well as number of planned patches and duration for use (number of hours per day). Therefore, medical necessity has not been established and is not medically necessary.