

<b>Case Number:</b>	CM13-0056784		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	07/07/2009
<b>Decision Date:</b>	04/07/2014	<b>UR Denial Date:</b>	10/22/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/22/2013

### 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 Internal Medicine, has a subspecialty in Pulmonary Diseases and is licensed to practice in California. He/she has been in active clinical practice for more than five years and is currently working least at 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 is a 55-year-old female who reported an injury on 07/07/2009. The mechanism of injury was not provided. The earliest documentation that discussed the medications Lidocaine and Norco were 03/28/2013. The patient was noted to undergo an L5-S1 anterior lumbar decompression and fusion with a placement of SynFix spacer, placement of a BMP, and placement of allograft on 06/26/2013. The documentation dated 10/10/2013 revealed the patient had pain that was typically of severe intensity without treatment on a regular basis. The pain was described as aching and a lancinating sensation in the primary area of discomfort. The patient indicated she was better able to perform their activities of daily living while receiving her current treatment. The patient indicated that the medication did produce an appreciable degree of pain relief. The patient's current medications were noted to be Medrox ointment, Norco 10/325, Cymbalta 30 mg, Lidocaine 5% ointment, Topamax 25 mg sprinkle cap, glipizide 10 mg, Glucophage 1000 mg tablets and insulin 1 ml syringe. The patient's diagnoses were noted to include thoracic and lumbosacral neuritis or radiculitis not otherwise specified, lumbar disc displacement without myelopathy, myalgia and myositis not otherwise specified, encounter for long term use of other medications, dysthymic disorder, and chronic pain syndrome, osteoarthritis not otherwise specified of the lower leg, lumbago, and pain in limb. The plan was noted to include chronic pain medications, anti-inflammatory medications, peripheral muscular medications, and stomach protective agents as well as topical agents to treat spasmodic and neuropathic component and a Toradol injection and a B12 injection.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Toradol/B12 injection: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Toradol, and the Pain, Vitamin B. Page(s): 72. Decision based on Non-MTUS Citation Official Disability Guidelines ODG

**Decision rationale:** California MTUS guidelines indicate that Toradol is not recommended for chronic pain. The physician indicated that the injection was to relieve acute and chronic symptoms. As it is not recommended, the Toradol injection would not be supported. As California MTUS and ACOEM do not address Vitamin B12, secondary guidelines were sought. Official Disability Guidelines indicate that vitamin B is not recommended as the efficacy is unclear. The physician opined that suprathreshold B12 supplementation enhanced pain relieving effects of other medications. However, as it is not recommended, the request for B12 injection would not be supported. Given the above, the request for a Toradol/B12 injection is not medically necessary.

**Cyclobenzaprine 7.5 mg, #60 with 3 refills: Upheld**

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

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

**Decision rationale:** California MTUS Guidelines indicate muscle relaxants are recommended as a second line options for short term treatment of acute low back pain. They are recommended for less than 3 weeks in duration. There should be documentation of objective functional improvement. There was a lack of documentation as to the first date of prescription for this medication. There was a lack of documentation indicating the patient had the necessity for 3 refills without reassessment. Given the above, the request for cyclobenzaprine 7.5 mg #60 with 3 refills is not medically necessary.

**Hydrocodone/Acetaminophen 2.5/325mg, #90 with 3 refills: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain, ongoing management Page(s): 60, 78.

**Decision rationale:** California MTUS Guidelines indicate that opiates are appropriate for the chronic pain. The patient was noted to be on Norco on 03/28/2013. There was a lack of

documentation indicating the patient had documented objective functional improvement and an objective decrease in the VAS score. There should be documentation the patient is being monitored for aberrant drug behavior and adverse side effects. Clinical documentation submitted for review indicated the patient had been on Norco since 03/28/2013. There was a lack of documentation indicating an objective functional increase as well as an objective decrease in the patient's Visual Analog Scale (VAS) score. There was documentation the patient was being monitored for adverse side effects as well as aberrant drug behavior through urine drug screens. There was a lack of documentation indicating a necessity for prescribing the medication with 3 refills without re-evaluation. Given the above, the request for hydrocodone/acetaminophen 2.5/325 #90 is not medically necessary.

**Lansoprazole Dr 30 mg, #30 with 3 refills: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 69.

**Decision rationale:** California MTUS Guidelines indicate that proton pump inhibitors are appropriate for dyspepsia due to NSAID therapy. The physician indicated that the medication is being prescribed on that date to reduce the possibility of the patient developing gastritis or ulcers. There was a lack of documentation; however, indicating the patient had signs or symptoms of dyspepsia. There was a lack of documentation indicating the duration the patient was on the medication and a necessity for 3 refills without re-assessment. Given the above, the request for lansoprazole DR 30 mg #30 with 3 refills is not medically necessary.

**Lodine 500mg, #60 with 3 refills: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 67.

**Decision rationale:** California MTUS Guidelines indicate that NSAIDS are appropriate for the treatment of low back pain after the use of Tylenol. There should be documentation of low back pain. This request was concurrently being reviewed with a medication including acetaminophen. There was a lack of documentation indicating the patient had a necessity for an NSAID with 3 refills. Subsequent documentation dated 10/25/2013 indicated the physician wanted the patient to stop the medication as the patient was still trying to fuse part of her spine. Given the above, the request for Lodine 500 mg #60 with 3 refills is not medically necessary.

**Tramadol Hcl Er 150mg, #30 with 3 refills: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain, ongoing management Page(s): 60, 78.

**Decision rationale:** California MTUS Guidelines indicate that opioids are appropriate treatment for chronic pain. There should be documentation of an objective improvement in functional, objective decrease in the VAS score and evidence the patient is being monitored for aberrant drug behavior and side effects. Clinical documentation submitted for review failed to indicate the duration the patient had been on the medication. Additionally, there was a lack of documentation indicating a necessity for 3 refills without re-evaluation. Given the above, the request for tramadol Hcl Er 150 mg #30 with 3 refills is not medically necessary.

**Lidocaine 5% ointment with 3 refills:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Lidocaine Page(s): 112.

**Decision rationale:** California MTUS indicates that topical analgesics are largely experimental in use with few randomized control trials to determine efficacy or safety, are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed, and any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Clinical documentation submitted for review indicated the patient had been on the medication with a duration greater than 9 months as the earliest documentation of the patient receiving the medication was 03/28/2013. There was a lack of documentation indicating the patient had trialed and failed antidepressants and anticonvulsants and Lidocaine is not recommended in any other form than a Lidoderm patch. No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. There was a lack of documentation of exceptional factors to warrant non-adherence to guideline recommendations. Given the above, the request for Lidocaine 5% ointment with 3 refills is not medically necessary.