

<b>Case Number:</b>	CM13-0062004		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	11/07/1993
<b>Decision Date:</b>	06/25/2014	<b>UR Denial Date:</b>	11/27/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/15/2013

### 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 Anesthesiology has a subspecialty in Pain Medicine and is licensed to practice in Florida, Pennsylvania. 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 patient sustained injury on 11/07/93 which appeared to be due to cumulative trauma. The patient had prior surgical history including discectomy in 1997 followed by lumbar fusion at L5-S1 in 1998. Revision fusion procedures were performed in 2000 or 2001. In 2007 the patient underwent adjacent level fusion at L4-5 and was followed for several years by pain management. The patient had unsuccessful spinal cord stimulator trial in 2012. There were further surgical recommendations by [REDACTED] on 12/12/12. Further surgical recommendations by [REDACTED] were noted in December of 2013 when the patient was recommended for an artificial disc replacement at L3-4. The patient was also followed by [REDACTED] for chronic pain. Per the 11/22/13 clinical record the patient had ongoing complaints of constant low back pain that was rated from 6-7/10 on VAS without with medications. Without medications the patient reported pain up to 9-10/10. On physical examination there was decreased range of motion of the lumbar spine all planes with positive straight leg raise findings bilaterally. Medications prescribed at this visit included Cyclobenzaprine 7.5mg, Omeprazole 20mg, Norco 10/325mg, and Percocet 10/325mg.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**ONE (1) DRUG SCREENING TEST:** 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 Chapter, Urine Drug Screens

**Decision rationale:** In regards to the request for a drug screen test, the last urine toxicology results were from 09/26/13 which noted positive results for hydrocodone. Prior to that there were toxicology results from 08/23/13 which again reported positive findings for hydrocodone. From the clinical documentation submitted there was no indication of any aberrant medication use or evidence that placed the patient at higher level of risk for abusing medications. Given that the patient had two recent consistent urine drug screen findings for controlled substances, the request for 1 drug screening test is not medically necessary and appropriate. .

**30 PERCOCET 10/325MG:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines MTUS California Chronic Pain Medical Treatment Guidelines (May 200).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines Opiates, Criteria for Use Page(s): 88-89.

**Decision rationale:** In regards to the request for percocet 10/325mg #30, the clinical documentation submitted did not establish any clear functional benefit obtained from percocet. Pain scores were minimally improved with multiple narcotic medications. Given the lack of any clear objective findings for ongoing functional improvement or substantial pain reduction, the request for 30 Percocet 10/325 is not medically necessary and appropriate.

**THREE (3) BOXES OF TEROGIN PATCHES:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines MTUS California Chronic Pain Medical Treatment Guidelines (May 200).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines MTUS Chronic Pain Medical Treatment Guidelines, Topical Analgesics Page(s): 111-113.

**Decision rationale:** In regards to the request for three boxes of terocin patches there was no indication from the clinical record that the patient had substantial side effects from oral medications or that any oral medications were contraindicated. Given that the current evidence based guidelines indicate that topical pain medications are largely experimental/investigational due to the lack of evidence regarding their efficacy for chronic pain patients as compared to oral medications, the request for 3 boxes of Terocin Patches is not medically necessary and appropriate.