

<b>Case Number:</b>	CM13-0062840		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	02/03/2006
<b>Decision Date:</b>	08/08/2014	<b>UR Denial Date:</b>	11/25/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/09/2013

### 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 Orthopedic Surgery 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 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 53 year-old individual who was reportedly injured on February 3, 2006. The mechanism of injury is not listed in these records reviewed. The most recent progress note, dated December 4, 2013, indicates that there are ongoing complaints of low back pain with bilateral lower extremity involvement. It is also noted that the injured employee is able to work full time in the heating and cooling business. The physical examination demonstrated an individual in no acute distress, normotensive, with tender to palpation in the lower lumbar region. Diagnostic imaging studies dating back to 2010 noted multiple level disc disease as well as foraminal stenosis. Previous treatment includes narcotic medications, transcutaneous electrical nerve stimulation and topical preparations. A request had been made for numerous items (listed below) and was not certified in the pre-authorization process on November 25, 2013.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**NERVE STUDIES:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

**Decision rationale:** In reviewing the most recent progress notes, there is no discussion as to the request of any nerve studies and there is no discussion as to what particular studies are being requested. Therefore, there is no clinical evidence presented, or medical necessity established for such overly broad and vague request.

**A TENS UNIT:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26. MTUS Page(s): 113-116 of 127.

**Decision rationale:** 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, if used as an adjunct to a program of evidence-based functional restoration, for the conditions described below. When noting that this individual has returned to work full time, and in the analgesic properties is pain with narcotic medications, there is no clinical indication for such a device. As such, there is no medical necessity established for this intervention.

**FLEXERIL 7.5MG #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26, MTUS (Effective July 18, 2009) Muscle relaxants Page(s): 41,64 of 127.

**Decision rationale:** When noting the date of injury, the actual injury sustained, the treatment currently rendered and the success with narcotic analgesics there is no clinical indication presented for the indefinite or chronic use of Cyclobenzaprine. This medication is indicated for short-term and chronic use. Therefore, this is not medically necessary.

**RETRO: FLEXERIL 7.5 MG #60 PROVIDED ON 11/6/2013:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26, MTUS (Effective July 18, 2009) Muscle relaxants Page(s): 41,64 of 127.

**Decision rationale:** When noting the date of injury, the actual injury sustained, the treatment currently rendered and the success with narcotic analgesics there is no clinical indication presented for the indefinite or chronic use of Cyclobenzaprine. This medication is indicated for short-term and chronic use. Therefore, this is not medically necessary.

**NEURONTIN 600MG #90: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS Page(s): 16-20,49 of 127.

**Decision rationale:** As outlined in the California Medical Treatment Utilization Schedule, this medication is effective for the treatment of a painful diabetic neuropathy or post-herpetic neuralgia. Neither malady exists. Furthermore, it is noted that this is a sprain/strain type situation with multiple level degenerative changes and no objective occasion of a lesion causing a neuropathic pain generator. Therefore, based on the records presented for review this is not medically necessary.

**RETRO: NEURONTIN 600MG #90 PROVIDED ON 11/6/2013: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 Page(s): 16-20,49 of 127.

**Decision rationale:** As outlined in the California Medical Treatment Utilization Schedule, this medication is effective for the treatment of a painful diabetic neuropathy or post-herpetic neuralgia. Neither malady exists. Furthermore, it is noted that this is a sprain/strain type situation with multiple level degenerative changes and no objective occasion of a lesion causing a neuropathic pain generator. Therefore, based on the records presented for review this is not medically necessary.

**TRAMADOL ER 150MG #30: Overturned**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS Page(s): 82,113 of 127.

**Decision rationale:** The California Medical Treatment Utilization Schedule outlines use of such analgesic medications for short-term relief when there has been a failure of first-line option. However, the utilization of this medication allows for a return to work in a full duty situation, demonstrating the efficacy and utility of deploying this type of medication. There are ongoing complaints of pain, findings on physical examination, and an ability to return to work. Therefore, the medical necessity has been established.

**RETRO: TRAMADOL ER 150MG #30 (11/6/2013): Overturned**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS Page(s): 82,113 of 127.

**Decision rationale:** The California Medical Treatment Utilization Schedule outlines use of such analgesic medications for short-term relief when there has been a failure of first-line option. However, the utilization of this medication allows for a return to work in a full duty situation, demonstrating the efficacy and utility of deploying this type of medication. There are ongoing complaints of pain, findings on physical examination, and an ability to return to work. Therefore, the medical necessity has been established.

**TEROCIN PATCHES #20: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26. MTUS Page(s): 112 of 127.

**Decision rationale:** This lotion is a topical analgesic ointment containing Methyl Salicylate 25%, Capsaicin 0.025%, Menthol 10%, and Lidocaine 2.50%. The MTUS notes that the use of topical medications is largely experimental and there have been few randomized controlled trials. It further goes on to note that topical Lidocaine is a secondary option when trials of antiepileptic drugs or antidepressants have failed. Based on the clinical documentation provided, pain relief is achieved with oral medications. As such, there is no clinical indication presented to suggest the need of a topical preparation in addition to the oral medication (which under separate cover has been endorsed). Therefore, the medical necessity of this preparation is not established.

**RETRO: TEROGIN PATCHES #20 (11/6/2013): Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26. MTUS Page(s): 112 of 127.

**Decision rationale:** This lotion is a topical analgesic ointment containing Methyl Salicylate 25%, Capsaicin 0.025%, Menthol 10%, and Lidocaine 2.50%. The MTUS notes that the use of topical medications is largely experimental and there have been few randomized controlled trials. It further goes on to note that topical Lidocaine is a secondary option when trials of antiepileptic drugs or antidepressants have failed. Based on the clinical documentation provided, pain relief is achieved with oral medications. As such, there is no clinical indication presented to suggest the

need of a topical preparation in addition to the oral medication (which under separate cover has been endorsed). Therefore, the medical necessity of this preparation is not established.

**LIDOPRO CREAM:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS Page(s): 56 of 127.

**Decision rationale:** Topical Lidocaine may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or California Medical Treatment Utilization Schedule anti-depressants or an anti-epileptic such as Gabapentin or Lyrica). This is not a first-line treatment and is only Food and Drug Administration approved for post-herpetic neuralgia. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than post-herpetic neuralgia. Therefore, based on the progress of presented for review this is not medically necessary.

**RETRO: LIDOPRO CREAM (11/6/2013):** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS Page(s): 56 of 127.

**Decision rationale:** Topical Lidocaine may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or Serotonin-norepinephrine reuptake inhibitors anti-depressants or an anti-epileptic such as Gabapentin or Lyrica). This is not a first-line treatment and is only FDA approved for post-herpetic neuralgia. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than post-herpetic neuralgia. Therefore, based on the progress of presented for review this is not medically necessary.

**NORCO 10/325MG #30:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26. MTUS Page(s): 74-78 of 127.

**Decision rationale:** The California Medical Treatment Utilization Schedule supports the use of short-acting opioids the treatment of severe breakthrough pain. It is noted under separate cover that an extended release analgesic medication is being employed. These analgesic allow for a

full duty return to work and significant pain relief. Therefore, based on the records reviewed there is some efficacy with the analgesic profile being completed, increase functionality and a full duty return to work. Therefore, this is determined to be medically necessary.