

<b>Case Number:</b>	CM13-0063959		
<b>Date Assigned:</b>	01/03/2014	<b>Date of Injury:</b>	03/11/2011
<b>Decision Date:</b>	04/30/2014	<b>UR Denial Date:</b>	12/02/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/11/2013

### 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 Physical Medicine & Rehabilitation and Pain 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 patient is a 57-year-old female who reported an injury on 03/11/2011 after a slip and fall that reportedly caused injury to her lumbar spine. The patient's chronic pain was managed with medications to include Ambien, Gralise, Vicoprofen, Motrin, and Lidoderm patches. The patient's most recent clinical evaluation documented that the patient had significant pain of the low back radiating into the lower extremities that limited her activities of daily living. Physical findings included restricted range of motion of the lumbar spine with a moderate straight leg raising test to the left. The patient's diagnoses included lumbar sprain/strain, lumbar degenerative disc disease, lumbar radiculopathy, and chronic pain syndrome. Future treatment recommendations included continuation of medication usage and lumbar epidural steroid injections.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Lidoderm Patch 5%, #30, x1:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, Page(s): 111.

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

**Decision rationale:** The requested Lidoderm patch 5% #30 times 1 is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends the continued use of Lidoderm patches be based on documentation of functional improvement and evidence of pain relief. The clinical documentation submitted for review does indicate that the patient has been on this medication since at least 12/2012. However, the patient's most recent clinical evaluation does not provide any evidence of pain relief or functional benefit from medication usage. Therefore, continued use of this medication would not be supported. As such, the requested Lidoderm patch 5% numbers 30 times 1 is not medically necessary or appropriate.

**Vicoprofen 7.5/200mg, #60, x1:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 76-80.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-Going Management, Page(s): 78.

**Decision rationale:** California MTUS guidelines recommend opiates for chronic pain. There should be documentation of an objective improvement in function, objective decrease in the VAS score, and evidence that the patient is being monitored for aberrant drug behavior and side effects. The requested Vicoprofen 7.5/200 mg #60 times 1 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends continued use of opioids in the management of chronic pain be supported by documentation of functional benefit, a quantitative assessment of pain relief, managed side effects, and evidence that the patient is monitored for aberrant behavior. The clinical documentation submitted for review does not provide any evidence that the patient receives any pain relief from medication usage. There is also not any documentation of functional benefit related to the use of this medication. Additionally, as the patient has been on this medication since at least 12/2012, there should be documentation that the patient is monitored for aberrant behavior. The clinical documentation does not include any evidence of any urine drug screens, pill counts, or a pain management contract with the treating physician. As such, the requested Vicoprofen 7.5/200 mg #60 times 1 is not medically necessary or appropriate

**Vistaril 25mg, #60, x1:** Upheld

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

**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, Insomnia Treatments.

**Decision rationale:** The requested Vistaril 25 mg #60 times 1 is not medically necessary or appropriate. The requested medication is typically used as a sedating antihistamine. The clinical documentation submitted for review does not provide an adequate assessment of the patient's sleep hygiene to support the need for pharmacological insomnia treatments. Additionally, the

documentation does not specifically identify the patient's failure to respond to no pharmacological interventions for sleep disturbances. As such, the requested Vistaril 25 mg #60 times 1 is not medically necessary or appropriate.

**Phenergan 12.5mg, #60, x1: Upheld**

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

**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, Anti-emetics.

**Decision rationale:** Promethazine (Phenergan<sup>®</sup>): Not recommended for nausea and vomiting secondary to chronic opioid use. The requested trial of Phenergan 12.5 mg #60 times 1 is not medically necessary or appropriate. Official Disability Guidelines do not recommend the treatment of nausea and vomiting related to medication usage. Additionally, the patient's most recent clinical evaluation does not provide any evidence that the patient has significant side effects related to the patient's medication schedule. Therefore, the need for a trial of Phenergan is not clearly established within the submitted documentation. As such, the requested trial of Phenergan 12.5 mg #60 times 1 is not medically necessary or appropriate.