

<b>Case Number:</b>	CM13-0066897		
<b>Date Assigned:</b>	01/03/2014	<b>Date of Injury:</b>	10/31/2002
<b>Decision Date:</b>	04/22/2014	<b>UR Denial Date:</b>	12/12/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/17/2013

### 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 Physical Medicine and Rehabilitation 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 patient is a 67 year old female who was injured on 10/31/2002. The mechanism of injury is unknown. Prior treatment history has included corticosteroid injection. Her previous injection provided over 50% relief. The patient stated pool therapy was the only thing that helped her. She will not go to physical therapy because she stated it makes everything worse. PR2 dated 09/18/2013 documented the patient to have complaints of ongoing neck and low back pain with symptoms extending into her bilateral knees and right-sided sciatica. She is concerned that with time, she is getting worse and having more significant complaints. Objective findings on exam revealed diffuse tenderness to palpation of the lumbar spine to the bilateral paraspinal region with some spasms appreciated. The sensation is diminished at the left L3, L4, and L5 dermatomes. The bilateral tibialis anterior, extensor hallucis longus and inversion are 4+/5 bilaterally. The bilateral quadriceps and hamstrings are 5-/5. The patient was diagnosed with 1) Chronic low back pain; 2) Multilevel disc herniations of lumbar spine; 3) Possible L5 pars defects; and 4) Lumbar radiculopathy. It was discussed with the patient that a home health aide at three times a week for six hours a day will be requested as well as a request for provided transportation to and from her visits. Given the rash, she was advised to discontinue the Neurontin. A prescription for Lyrica 75 mg #60 one p.o. b.i.d. and Prilosec 20 mg #60 one p.o. b.i.d. was provided. PR2 dated 08/22/2013 indicated the patient remains on her medications which include Zoloft 100 mg bid, Deplin 15 mg q am, and Valium 10 mg at h.s. which she reports was helpful. PR2 dated 08/14/2013 documented the patient to have complaints of pain which she rated as 7/10. Her left knee was causing her the most pain. She stated she has had a recent flare up of her right shoulder after increasing her home exercise plan. Her medications included Naproxen 550 mg, Prilosec for GI upset, Lyrica, and Actonel. The medications help decrease her pain and increase her function. Home evaluation note dated 07/29/2013 revealed the

patient's living conditions remained the same. She stated that she will need help on a daily basis when she has her left knee done. She has set up for several friends to come in and check in on her cats. She cannot do any lifting or bending. She cannot carry or unload her own groceries. She cannot stand up for more than 3-4 minutes on her worst day and maybe for 15 minutes on a good day. She stated driving aggravates her neck and back. On a good day her pain is 9/10 and on really bad days it is 10/10/ even with pain meds. She cannot get out of bed without taking 2 Norco. She is taking 3 Norco daily and has increased her Fentanyl pain patch to 75 mcg. She uses a cane always when outside and a walker when the pain is really bad. She needs total assistance with all the cleaning, laundry, dusting, vacuuming, changing sheets and making her bed. Her caregivers do all the grocery shopping for her. If she needs to go to the store, she uses her steel rolling cart to bring her things in. She is independent with bathing, eating and making her own meals. Her medication is as follows: 3 Norco daily; Naproxen 2 daily; 75 mcg Fentanyl patch; Zolof 100 mg BID; Lyrica 75 mg BID; Omeprazole 20 mg BID; Actonel 35 mg per week; and Levoxyl 88 mcg daily. Her son lives close by, but has 2 full time jobs and doesn't come by as often as he used to. She stated that having 3-6 hour shifts a week are working very well. The recommendation was for her care to remain the same. She will need to be re-evaluated when her knee surgery is scheduled and will require more care post surgery especially if her going to a rehab for 10 days request is denied.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**LYRICA 75 MG, #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Pregabalin (Lyrica®) Page(s): 99.

**Decision rationale:** According to the guidelines, Lyrica is effective in treatment of diabetic neuropathy and postherpetic neuralgia, and is considered a first-line treatment for these conditions. The medical records do not establish this patient has either of these conditions. Consequently, the medical necessity of Lyrica has not been established.

**ONE HOME HEALTH AIDE, 3 TIMES PER WEEK, FOR SIX WEEKS:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Home Health Services Page(s): 51.

**Decision rationale:** According to the guidelines, home health services are recommended medical treatment for patients who are homebound, on a part-time or "intermittent" basis, generally up to no more than 35 hours per week. The medical records do not establish a clinical

rationale for these requested services. The documentation in the medical records outlines that the patient has friends and family available, that can assist her with home-maker activities, if needed. Furthermore, an individual should be encouraged to perform self-care activities and to stay as active as possible, to maintain functional levels. Enabling behaviors or situations should be avoided. The medical records do not establish the patient meets the criteria to warrant consideration for home health care services.