

<b>Case Number:</b>	CM13-0070363		
<b>Date Assigned:</b>	01/03/2014	<b>Date of Injury:</b>	01/29/2009
<b>Decision Date:</b>	05/29/2014	<b>UR Denial Date:</b>	11/26/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/24/2013

### 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 underlying date of injury in this case is 01/29/2009. The patient's diagnosis is a lumbar post laminectomy syndrome. On 08/13/2013, the patient was seen in comprehensive follow-up by her primary treating physician. The patient reported that she was not improved significantly. Authorization had been approved for bilateral L2 and L3 Rhizotomy. The patient's neurological examination was unchanged, with normal strength in the lower extremities. The patient was diagnosed with lumbar disc disease and a lumbar post laminectomy syndrome. Medications were refilled, including Percocet, Zolpidem, Prilosec, Voltaren topically, and oral diclofenac. Follow-up was planned in a month. As of 10/22/2013, the patient was seen in follow-up regarding chronic pain. The patient noted that the Rhizotomy did not help. Her pain was 8/10, and she was noted to have tenderness over the sacroiliac joint and a positive FABER sign. The patient's medications were renewed.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**PERCOCET 10/325 #90:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS/ONGOING MANAGEMENT Page(s): 78.

**Decision rationale:** The California Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines, section on opioids/ongoing management, page 78, discusses at length the four A's of opioid management. These guidelines do not recommend opioids as the first line of treatment for chronic low back pain. Moreover, the medical records in this case do not clearly indicate functional benefit or an overall risk versus benefit analysis of opioid medications consistent with the four A's of opioid management. This request is not supported by the guidelines. This request is not medically necessary.

**ZOLPIDEM 10MG #30:** Overturned

**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/Insomnia Management.

**Decision rationale:** Zolpidem is not specifically discussed in the California Medical Treatment Utilization Schedule. This medication is discussed in the Official Disability Guidelines/Treatment in Workers Compensation/Pain/Insomnia Management, which recommends Zolpidem for short-term treatment of insomnia up to 7-10 days. The medical records in this case provide very limited information regarding indication or rationale or benefit of Zolpidem for chronic use. This request is not supported by the guidelines. This request is not medically necessary.

**PRILOSEC 20MG #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Inflammatory Medications and Gastrointestinal Symptoms Page(s): 68.

**Decision rationale:** The California Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines, section on anti-inflammatory medications and gastrointestinal symptoms, page 68, recommends that the clinician should determine if the patient is at risk for gastrointestinal events. The medical records do not discuss indications as to why this patient requires gastrointestinal prophylaxis. This request is not supported by the medical records. This request is not medically necessary.

**VOLTAREN GEL #5:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL ANALGESICS Page(s): 111-112.

**Decision rationale:** The California Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines, section on topical analgesics, recommends the use of topical anti-inflammatory medications only for short-term use. Moreover, these guidelines specifically state that Voltaren Gel has not been tested for the spine. The medical records do not provide an alternate rationale in this case to as why this medication would be indicated. Moreover, it is not clear why this patient has been prescribed both oral and topical anti-inflammatory medications. Overall this request is not medically necessary.