

<b>Case Number:</b>	CM14-0130192		
<b>Date Assigned:</b>	08/20/2014	<b>Date of Injury:</b>	12/22/1998
<b>Decision Date:</b>	09/29/2014	<b>UR Denial Date:</b>	07/16/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/14/2014

### 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 Nevada. 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 records, presented for review, indicate that this 32-year-old individual was reportedly injured on December 20, 1998. The mechanism of injury was not listed in these records reviewed. The most recent progress note, dated July 20, 2014, indicated that there were ongoing complaints of low back pain. The physical examination demonstrated a 5'9", 255 pound individual who is normotensive (110/80). There was tenderness to palpation along the paraspinous musculature of the lumbar region, of the spine. A decrease in lumbar spine range of motion was also noted. There was no atrophy in the bilateral lower extremities, and there was no weakness and deep tendon reflexes were noted to be equal and symmetric. Diagnostic imaging studies were not reported. Previous treatment included multiple medications, physical therapy, and pain management interventions. A request had been made for multiple medications and was not certified in the pre-authorization process on July 16, 2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Lidocaine 5% Patches (700mg) #30 Refill: 2:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm(Lidocaine).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 56.

**Decision rationale:** As outlined in the MTUS, this medication is recommended for localized peripheral pain associated with neuropathic lesions. There is no objectification that there is a specific neuropathic lesion. As such, based on the clinical records presented for review, the medical necessity for this topical preparation has not been established.

**Norco 10-325mg #60 Refill: 2:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-78, 88, 91.

**Decision rationale:** This is a short acting opioid indicated for the management of moderate to severe breakthrough pain. However, when noting the prescriptions assigned, it is clear that this is a chronic, indefinite medication. Furthermore, this is to use the lowest possible dose to improve pain and function. However, there is no objectification of functional improvement or decrease in pain symptomatology. Therefore, the efficacy and utility of this medication has not been objectified. Therefore, the request is not medically necessary.

**Voltaren Gel 3 Tubes/Month, X2 Months Refill:2:** Upheld

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

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

**Decision rationale:** MTUS guidelines support the topical diclofenac for the relief of osteoarthritic pain of the ankle, elbow, foot, hand, knee and wrist. It has not been evaluated for treatment of the spine, hip or shoulder. Outside of the treatment of osteoarthritis, there is no other clinical indication for the use of this topical non-steroidal anti-inflammatory. The claimant suffers from low back pain. There is no indication for this medication, and the request is not considered medically necessary.

**Tramadol 50mg #90 Refill:2:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol (Ultram).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 82, 113.

**Decision rationale:** MTUS treatment guidelines support the use of tramadol (Ultram) for short-term treatment of moderate to severe pain after there has been evidence of failure of a first-line

option and documentation of improvement in pain and function with the medication. Given the claimant's date of injury, clinical presentation and current diagnosis, the guidelines do not support the use of this medication. As such, this request is not considered medically necessary.