

<b>Case Number:</b>	CM14-0136732		
<b>Date Assigned:</b>	09/03/2014	<b>Date of Injury:</b>	12/13/2004
<b>Decision Date:</b>	10/02/2014	<b>UR Denial Date:</b>	08/20/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/25/2014

### 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 & Rehabilitation, has a subspecialty in Interventional Spine 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 60-year-old female with a date of injury of 12/13/2004. The listed diagnoses per [REDACTED] are: 1. Lumbago. 2. Low back pain. 3. Low back syndrome. 4. Lumbosacral spondylosis without myelopathy. 5. Lumbar arthritis, osteoarthritis, and spondylosis. According to progress report 08/06/2014, the patient presents with continued low back pain. Examination of the lower back revealed paraspinal muscle tenderness with decreased range of motion. Straight leg raising test is positive at 50 degrees in a sitting position. The patellar reflexes on both sides are 1/10. The ankle jerk reflexes on both sides are 1/4. Patient's gait is antalgic, slow, and assisted by cane. Medication regimen includes Ambien, Lidoderm patches, Norco 10/325 mg, Zanaflex 4 mg, and Dexilant 30 mg. The patient is currently not working. The treater is requesting a refill of medications. Utilization review denied the request on 08/20/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Norco 10/325 Mg #210:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Long-term Opioid use Page(s): 88-89.

**Decision rationale:** This patient presents with chronic low back pain. The treater is requesting a refill of Norco 10/325 mg #210. The MTUS Guidelines pages 88 and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4As (analgesia, ADLs, adverse side effects, and adverse behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. This patient has been prescribed this medication since at least 03/05/2014. Review of the medical file which includes progress reports from 02/28/2014 through 08/06/2014 requests a refill of this medication, but the treater does not discuss efficacy in terms of pain relief or functional improvement. In fact, progress report 07/01/2014 by [REDACTED] states, "Quality of life has worsened. His activity level has decreased. This patient is taking his medications as prescribed. He states his medications are not effective." The request is not medically necessary.

**Zanaflex 4 Mg Tablets #60:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Zanaflex; ANTISPASTICITY/ANTISPASMODIC DRUGS Page(s): 66.

**Decision rationale:** This patient presents with chronic low back pain that radiates down to the lower extremity. The treater is requesting a refill of Zanaflex 4 mg #60. The MTUS Guidelines page 66 allows for the use of Zanaflex (tizanidine) for low back pain, myofascial pain, and fibromyalgia. Review of the medical file indicates the patient has been prescribed this medication since at least 03/05/2014. Review of subsequent progress reports does not provide discussion regarding this medication's efficacy. There is no pain scale or documentation of functional improvement with taking Zanaflex. MTUS page 60 requires documentation of pain assessment and functional changes when medications are used for chronic pain. The request is not medically necessary.

**Dexilant 30 Mg Capsules # 60:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation <https://www.dexilanthcp.com/default.aspx>

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 69.

**Decision rationale:** This patient presents with chronic low back pain that radiates into the bilateral lower extremities. The treater is requesting a refill of Dexilant 30 mg #60. The MTUS Guidelines page 68 and 69 state that omeprazole is recommended with precaution for patients at

risk for gastrointestinal events: (1) Age is greater than 65, (2) History of peptic ulcer disease and GI bleeding or perforation, (3) Concurrent use of ASA or corticosteroid and/or anticoagulant, (4) High dose/multiple NSAID. In this case, there is no indication that the patient is taking NSAID to consider the use of Dexilant. Furthermore, the treater states the patient complains of heartburn but provides no discussion regarding GI issues such as gastritis, ulcers, or reflux that requires the use of this medication. The request is not medically necessary.

**Lidoderm 5% Patches:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines lidoderm patches Page(s): 56-57.

**Decision rationale:** This patient presents with chronic low back pain that radiates into the bilateral lower extremities. The treater is requesting a refill of Lidoderm 5% patches. MTUS guidelines page 57 states, "topical lidocaine may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica)." MTUS Page 112 also states, "Lidocaine Indication: Neuropathic pain Recommended for localized peripheral pain." When reading ODG guidelines, it specifies that Lidoderm patches are indicated as a trial if there is "evidence of localized pain that is consistent with a neuropathic etiology." ODG further requires documentation of the area for treatment, trial of a short-term use with outcome documenting pain and function. In this case, the patient does not present with localized peripheral pain. The treater appears to be prescribing the patches for the patient's low back pain, which is not supported by the guidelines. The requested Lidoderm patches are not medically necessary.