

<b>Case Number:</b>	CM14-0044294		
<b>Date Assigned:</b>	07/02/2014	<b>Date of Injury:</b>	08/06/2010
<b>Decision Date:</b>	08/22/2014	<b>UR Denial Date:</b>	04/02/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/11/2014

### 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 44 year old female was reportedly injured on 8/6/2010. The mechanism of injury is noted as a fall. The most recent progress note dated 3/13/2014, indicates that there are ongoing complaints of low back pain. Physical examination demonstrated tenderness to right sacroiliac (SI) joint; lumbar range of motion: flexion 45 degrees, extension 0 degrees, lateral bending 15 degrees with pain, rotation 30 degrees; knee/ankle reflexes 2+; sensation normal; motor strength 5/5 in lower extremities; negative straight leg raise test; positive right sided FABER; Patrick's, Gaenslen and Thigh thrust tests; and normal gait. Electromyogram and nerve conduction studies (EMG/NCV) demonstrated chronic right L5-S1 radiculopathy. No recent diagnostic imaging studies are available for review. Diagnosis of right sacroiliac joint dysfunction was documented. Previous treatment includes several sacroiliac (SI) joint injections, home exercise program and medications to include Norco, Relafen and Lidoderm patch. A request was made for Norco 10/325 milligrams #120, Relafen 750 milligrams #60, and Lidoderm patch 5 percent #30 which were not certified in the utilization review on 4/2/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Norco 10/325 #120:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines : 8 C.C.R. 9792.20 - 9792.26. MTUS (Effective July 18, 2009) Page(s): 74-78 of 127.

**Decision rationale:** Norco (Hydrocodone/acetaminophen) is a short-acting opioid combined with acetaminophen. Medical Treatment Utilization Schedule (MTUS) guidelines support short acting opiates for the short term management of moderate to severe breakthrough pain. Management of opiate medications should include the lowest possible dose to improve pain and function, as well as the ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects. The claimant has chronic back pain, which is felt to be due to sacroiliac joint dysfunction; however, there is no clinical documentation of improvement in their pain or function with the current regimen. As such, this request is not medically necessary.

**Relafen 750MG #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines : 8 C.C.R. 9792.20 - 9792.26. MTUS (Effective July 18, 2009) Page(s): 72.

**Decision rationale:** Relafen is a nonselective, non-steroidal anti-inflammatory medication with an indication for osteoarthritis per Medical Treatment Utilization Schedule (MTUS) treatment guidelines. The use of this medication for moderate pain is off label per the packet insert. When noting the claimant's clinical presentation and current diagnosis, there is no clinical indication for the use of this medication. As such, this request is not medically necessary.

**Lidoderm patch 5% #30:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines : 8 C.C.R. 9792.20 - 9792.26. MTUS (Effective July 18, 2009) Page(s): 56, 57, 112 of 127.

**Decision rationale:** Medical Treatment Utilization Schedule (MTUS) guidelines support the use of topical lidocaine for individuals with neuropathic pain that have failed treatment with first line therapy including antidepressants or antiepilepsy medications. Based on the clinical documentation provided, the claimant does not meet the criteria for this request. As such, Lidoderm patches are not medically necessary.