

<b>Case Number:</b>	CM14-0049854		
<b>Date Assigned:</b>	07/07/2014	<b>Date of Injury:</b>	09/26/2005
<b>Decision Date:</b>	08/01/2014	<b>UR Denial Date:</b>	04/11/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/17/2014

### 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 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 injured worker is a 55-year-old male who reported an injury on 09/26/2005 due to a fall of approximately 2 stories. The injured worker reportedly sustained an injury to his nose, back, and right shoulder. The injured worker's treatment history included physical therapy, multiple medications, a pain stimulator and immobilization. The injured worker was monitored for aberrant behavior with urine drug screens. The injured worker was evaluated on 04/07/2014. It was noted that the patient had 8/10 pain that was mildly reduced with medications. Physical findings included restricted lumbar range of motion secondary to pain, positive lumbar facet loading, and a positive right-sided straight leg raising test. It was also noted that there was diminished sensation in the right L5-S1 dermatomal distribution with equal reflexes in the bilateral lower extremities except the right ankle and right patellar reflex. The injured worker's diagnoses included thoracic or lumbosacral neuritis or radiculitis, osteoarthritis of the lower extremities, and unspecified internal derangement of the knee. The injured worker's medications included fentanyl 50 mg and 12 mcg/hour patches, Dilaudid 8 mg 3 times a day, Cymbalta 60 mg 1 every day, Lidoderm patches 5% (3 patches every 12 hours), and diclofenac gel apply to affected area 4 times a day as needed. Request was made for an epidural steroid injection and a refill of medications.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Lumbar Epidural Steroid Injection at L5-S1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303, Chronic Pain Treatment Guidelines Epidural Steroid injections (ESIs).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections Page(s): 46.

**Decision rationale:** California MTUS Chronic Pain Medical Treatment Guidelines recommends that epidural steroid injections be supported by documented physical findings corroborated by an imaging study or electrodiagnostic study that have failed to respond to conservative treatment. The clinical documentation submitted for review does indicate that the patient has clinical examination findings of radiculopathy supported by an imaging study. The clinical documentation submitted for this review did not include an imaging study or an electrodiagnostic study to support the need for an epidural steroid injection. As such, the requested lumbar epidural steroid injection at the L5-S1 is not medically necessary or appropriate.

**Cymbalta 60mg #30 with 2 refills:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-depressants Page(s): 60 and 13.

**Decision rationale:** California MTUS Chronic Pain Medical Treatment Guidelines do recommend the use of antidepressants as a first line medication in the management of chronic pain. However, California MTUS Chronic Pain Medical Treatment Guidelines states that medications used in the management of chronic pain be supported by documented functional benefit and evidence of pain relief. The clinical documentation submitted for review does indicate that the patient has some pain relief from medication usage. However, there is no documented functional benefit resulting from the use of medications. Also, the request includes 2 refills. This does not allow for timely reassessment of efficacy to support continued use. Furthermore, the request as it is submitted does not clearly identify a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Cymbalta 60 mg #30 with 2 refills is not medically necessary or appropriate.

**Lidoderm 5% patches #90:** Upheld

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

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

**Decision rationale:** California MTUS Chronic Pain Medical Treatment Guidelines recommends the use of this treatment option when patients have failed a trial of oral anticonvulsants. The

clinical documentation fails to identify that the patient has not responded to oral anticonvulsants and would benefit from the use of topical Lidoderm. Also, California MTUS Chronic Pain Medical Treatment Guidelines recommends continued use of any medication used in the management of chronic pain be supported by documented functional benefit and evidence of pain relief. The clinical documentation does indicate that the patient has mild pain relief resulting from usage. However, there is no specific documentation of functional benefit to support continued use. Furthermore, the request as it is submitted does not specifically identify a body part or frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Lidoderm 5% patches #90 are not medically necessary or appropriate.

**Diazepam 10mg #90: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

**Decision rationale:** California MTUS Chronic Pain Medical Treatment Guidelines do not recommend the long-term use of benzodiazepines due to the high risk of psychological and physiological dependence. The clinical documentation submitted for review does indicate that the patient has been on this medication since at least 10/2013. Additionally, there is no documentation of functional benefit resulting from the use of this medication. Furthermore, the request as it is submitted does not specifically identify a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested diazepam 10 mg #90 is not medically necessary or appropriate.

**Dilaudid 8 mg #120: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-Going Management Page(s): 78.

**Decision rationale:** The California MTUS Chronic Pain Medical Treatment Guidelines recommends the ongoing use of opioids in the management of chronic pain be supported by documented functional benefit, evidence of pain relief, managed side effects and evidence that the patient is monitored for aberrant behavior. The clinical documentation does indicate that the patient has been on this medication for a significant period of time. However, a quantitative assessment of pain relief is not provided. Additionally, there was no documentation of functional benefit to support continued use. Furthermore, the request as it is submitted does not clearly identify a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Dilaudid 8 mg #120 is not medically necessary or appropriate.

