

<b>Case Number:</b>	CM14-0050271		
<b>Date Assigned:</b>	09/03/2014	<b>Date of Injury:</b>	08/28/2003
<b>Decision Date:</b>	10/03/2014	<b>UR Denial Date:</b>	02/27/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/24/2014

### 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 and is licensed to practice in Illinois. 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 65-year-old male who reported an injury on 08/28/2003. The mechanism of injury was not provided for clinical review. The diagnoses included status post left lateral epicondylitis release, status post left ulnar nerve transposition, right cubital tunnel, right lateral epicondylitis, status post cervical spine fusion. Previous treatments included physical therapy, medication, home exercise and epidural steroid injections. Diagnostic testing included x-rays and EMG/NCV. Within the clinical note dated 04/10/2014 it was reported the injured worker complained of low back pain. He rated his pain 6/10 in severity. He described the pain as numbness, shooting, stabbing and tingling. He reported the pain was intermittent. The injured worker reported the numbness and the tingling were in the right lower extremity. On the physical examination, the provider noted the injured worker had a forward flexed body posture. The lumbar spine had tenderness noted over the paraspinal muscles overlaying the facet joints on the right side. The range of motion of the lumbar spine was within normal limits except for extension which was limited to 10 degrees with pain. The provider noted the injured worker had negative facet loading. On the examination of the lower extremities, the provider noted the injured worker had tenderness to palpation over the gluteus medius of the right lower extremity. The provider requested oxycodone for pain, Lidoderm patch for pain, Voltaren gel for pain, gabapentin, EMG of the right lower extremity, and TENS unit. However, the rationale was not provided for clinical review. The Request for Authorization was not provided for clinical review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Oxycodone 15 mg #90: Upheld**

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

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

**Decision rationale:** The California MTUS Guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects. The guidelines recommend the use of a urine drug screen or inpatient treatment with issues of abuse, addiction or poor pain control. There is lack of documentation indicating the efficacy of the medication is evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. Additionally, the use of a urine drug screen was not provided for clinical review. Therefore the request for oxycodone 15 mg #90 is not medically necessary.

**Oxycodone 15mg #90: Upheld**

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

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

**Decision rationale:** The California MTUS Guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects. The guidelines recommend the use of a urine drug screen or inpatient treatment with issues of abuse, addiction or poor pain control. There is lack of documentation indicating the efficacy of the medication is evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. Additionally, the use of a urine drug screen was not provided for clinical review. Therefore the request for oxycodone 15 mg #90 is not medically necessary.

**Lidoderm Patch 5% #30 with 2 refills: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical lidocaine. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain (Chronic) Criteria for the use of Lidoderm Patches

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical NSIADs Page(s): 111-113.

**Decision rationale:** The California MTUS guidelines note topical NSAIDS are recommended for osteoarthritis and tendinitis. In particular, that of the knee and/or elbow and other joints that

are ambulatory. Topical NSAIDS are recommended for short term use of 4 to 12 weeks. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. Additionally, the injured worker had been utilizing the medication for an extended period of time since at least 01/2014 which exceeds the guidelines recommendation of short term use. Therefore the request for Lidoderm patch 5% #30 with 2 refills is not medically necessary.

**Voltaren 1% gel (quantity unknown) with 2 refills:** Upheld

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

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

**Decision rationale:** The California MTUS Guidelines note topical NSAIDS are recommended for osteoarthritis and tendinitis, in particular, that of the knee and/or elbow and other joints that are ambulatory. Topical NSAIDS are recommended for short term use of 4 to 12 weeks. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The injured worker has been utilizing the medication since at least 01/2014 which exceeds the guidelines recommendation of short term use of 4 to 12 weeks. Additionally, the request submitted failed to provide the frequency of the medication. The request submitted failed to provide the quantity of the medication. The request submitted failed to provide the treatment site. The request for Voltaren 1% gel quantity unknown with 2 refills is not medically necessary.

**Gabapentin 600 mg #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin Page(s): 18-19.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin Page(s): 49.

**Decision rationale:** The California MTUS Guidelines show that Gabapentin has been shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first line treatment for neuropathic pain. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. Therefore the request for Gabapentin 600 mg #90 is not medically necessary.

**EMG (electromyography) of the right lower extremity:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back- Lumbar & Thoracic (Acute & Chronic)

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

**Decision rationale:** The California MTUS/ACOEM Guidelines note EMG studies are useful to assist when identification of neurological dysfunction in patients with low back symptoms when examination findings are unclear. The guidelines recommend the documentation of failure of conservative care to alleviate symptoms. There is lack of documentation indicating the injured worker had tried and failed in conservative therapy. There is lack of significant neurological deficits such as decreased sensation of motor strength in a specific dermatomal or myotomal distribution. Therefore the request for an EMG of the right lower extremity is not medically necessary.

**TENS unit with supplies (duration and quantity unknown):** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS, Chronic Pain, ( trans-cutaneous electrical nerve stimulation.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy Page(s): 114-116.

**Decision rationale:** The California MTUS Guidelines do not recommend a TENS unit as a primary treatment modality. A 1 month home based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence based functional restoration. There is evidence that other appropriate pain modalities have been tried and failed including medication. There is lack of significant deficits upon the physical examination warranting the medical necessity for the request. There is lack of documentation indicating the injured worker had failed in conservative therapy, or the provider requesting physical therapy along with utilization of a TENS unit. The request submitted failed to provide the duration and quantity. Therefore the request for TENS unit with supplies (duration and quantity unknown) is not medically necessary.