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| <b>Case Number:</b>   | CM14-0058519 |                              |            |
| <b>Date Assigned:</b> | 07/09/2014   | <b>Date of Injury:</b>       | 05/12/1993 |
| <b>Decision Date:</b> | 08/29/2014   | <b>UR Denial Date:</b>       | 04/11/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 04/29/2014 |

### 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 Emergency Medicine 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:

According to the records made available for review, this is a 42-year-old female with a 9/30/10 date of injury. At the time (4/4/14) of request for authorization for Lidoderm patch 5% #30, there is documentation of subjective (radicular neck pain) and objective (restricted cervical range of motion, tenderness to palpation over the cervical paravertebral muscles with spasm, pain with Spurling's maneuver, absent biceps and brachioradialis reflexes on the left, decreased motor strength of the LUE, and decreased sensation over the left C5-C7 dermatome) findings, current diagnoses (cervical radiculopathy, cervical post-laminectomy syndrome, and cervical pain), and treatment to date (ongoing therapy with Lidoderm Patch, Lyrica and Naprosyn with pain relief and increased activities of daily living). There is no documentation of evidence that a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as Gabapentin or Lyrica) has failed.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Cyclobenzaprine 5mg #120:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines CA MTUS Chronic Pain Treatment Guidelines, Muscle Relaxants Page(s): 63-66.

**Decision rationale:** The requested Cyclobenzaprine 5mg #120 is not medically necessary. CA MTUS Chronic Pain Treatment Guidelines, Muscle Relaxants, pages 63-66, do not recommend muscle relaxants as more efficacious than NSAIDs and do not recommend use of muscle relaxants beyond the acute phase of treatment. The injured worker has chronic low back pain. The treating physician has documented facet joint tenderness and paraspinal trigger points, negative straight leg raising tests, normal neurologic exam. The treating physician has not documented intolerance to NSAID treatment, duration of treatment nor objective evidence of derived functional improvement from its previous use. The criteria noted above not having been met, Cyclobenzaprine 5mg #120 is not medically necessary.

**Amitriptyline 50mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines CA MTUS Chronic Pain Treatment Guidelines, Antidepressants for Chronic Pain Page(s): 13-15.

**Decision rationale:** The requested Amitriptyline 50mg #60 is not medically necessary. CA MTUS Chronic Pain Treatment Guidelines, Antidepressants, Pages 13-15, recommend tricyclic antidepressants as a first-line agent for the treatment of chronic pain, neuropathic pain and depression, unless they are ineffective, poorly tolerated, or contraindicated. The injured worker has chronic low back pain. The treating physician has documented facet joint tenderness and paraspinal trigger points, negative straight leg raising tests, normal neurologic exam. The treating physician has not documented duration of treatment or objective evidence of derived functional improvement from its use. The criteria noted above not having been met, Amitriptyline 50mg #60 is not medically necessary.

**OxyContin ER 10mg #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines CA MTUS Chronic Pain Treatment Guidelines, Opioids, On-Going Management, Pages 78-80, Opioids for Chronic Pain, Pages 80-82; Weaning of Medications Page(s): 124.

**Decision rationale:** The requested OxyContin ER 10mg #60 is not medically necessary. CA MTUS Chronic Pain Treatment Guidelines, Opioids, On-Going Management, Pages 78-80, Opioids for Chronic Pain, Pages 80-82, recommend continued use of this opiate for the treatment of moderate to severe pain, with documented objective evidence of derived functional benefit, as well as documented opiate surveillance measures; and Weaning of Medications, Page 124 recommend a slow taper of medications. The injured worker has chronic low back pain. The

treating physician has documented facet joint tenderness and paraspinal trigger points, negative straight leg raising tests, normal neurologic exam. The treating physician has also documented that there will be a continuation of opioid weaning with the goal of 100 to 130 MED and subsequent opioid detoxification program. The current opiate load is 110 mg per day for 165 MED as of March 26, 2014. As of October 17, 2013, current opiate dosages as Oxycontin ER 20 mg per day and Oxycontin ER 40 mg tid with a 20 mg per month weaning process. The opiate load is 140 mg per day for 210 MED. The treating physician has documented a 30 mg taper over six months, which is in excess of the reported plan of 20 mg decrease per month. The treating physician has not documented the results of urine drug screening during the weaning process. The treating physician has not documented VAS pain quantification with and without medications, objective evidence of derived functional benefit such as improvements in activities of daily living or reduced work restrictions or decreased reliance on medical intervention, nor measures of opiate surveillance including an executed narcotic pain contract. The criteria noted above not having been met, OxyContin ER 10mg #60 is not medically necessary.

**OxyContin ER 30mg #90:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines CA MTUS Chronic Pain Treatment Guidelines, Opioids, On-Going Management, Pages 78-80, Opioids for Chronic Pain, Pages 80-82; Weaning of Medications Page(s): 124.

**Decision rationale:** The requested OxyContin ER 30mg #90 is not medically necessary. CA MTUS Chronic Pain Treatment Guidelines, Opioids, On-Going Management, Pages 78-80, Opioids for Chronic Pain, Pages 80-82, recommend continued use of this opiate for the treatment of moderate to severe pain, with documented objective evidence of derived functional benefit, as well as documented opiate surveillance measures; and Weaning of Medications, Page 124 recommend a slow taper of medications. The injured worker has chronic low back pain. The treating physician has documented facet joint tenderness and paraspinal trigger points, negative straight leg raising tests, normal neurologic exam. The treating physician has also documented that there will be a continuation of opioid weaning with the goal of 100 to 130 MED and subsequent opioid detoxification program. The current opiate load is 110 mg per day for 165 MED as of March 26, 2014. As of October 17, 2013, current opiate dosages as Oxycontin ER 20 mg per day and Oxycontin ER 40 mg tid with a 20 mg per month weaning process. The opiate load is 140 mg per day for 210 MED. The treating physician has documented a 30 mg taper over six months, which is in excess of the reported plan of 20 mg decrease per month. The treating physician has not document the results of urine drug screening during the weaning process. The treating physician has not documented VAS pain quantification with and without medications, objective evidence of derived functional benefit such as improvements in activities of daily living or reduced work restrictions or decreased reliance on medical intervention, nor measures of opiate surveillance including an executed narcotic pain contract. The criteria noted above not having been met, OxyContin ER 30mg #90 is not medically necessary.