

<b>Case Number:</b>	CM14-0078656		
<b>Date Assigned:</b>	07/18/2014	<b>Date of Injury:</b>	10/23/2009
<b>Decision Date:</b>	09/17/2014	<b>UR Denial Date:</b>	04/29/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/29/2014

### 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 Physical Medicine and Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Texas. 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 43 year old female injured on 10/23/09 due to an undisclosed mechanism of injury. The documentation indicates the injured worker later stepped off a curb on 04/01/14 and felt her back snap and was later unable to bear weight on her right lower extremity and reported severe low back pain. The injured worker presented to the emergency department where CT scan was performed and the injured worker was referred to orthopedic specialist. Clinical note dated 04/18/14 indicates the injured worker presented complaining of weakness in the right lower extremity and increased shooting pain in the low back referring to the buttocks. The injured worker also complained of significant muscle spasm and dystonia with lancinating paroxysmal neuropathic pain. The documentation indicates the injured worker remains symptomatic with bilateral upper extremity pain affecting the hands and elbows with decreased grip strength. Previous treatment included lumbar surgery with revision, weight loss program, aquatic therapy, selective nerve root blocks, individual psychotherapy, and medication management. The injured worker rated pain at 5-6/10 with the use of medications with a range of 3-8/10. The injured worker reports 70% improvement in pain. The injured worker reported increase in activities to include light housekeeping, cooking, grocery shopping, caring for her child, and activities of daily living with the use of medications. Medications include Norco 10/325 mg q 4-6 hours, Baclofen 20 mg tid, and Dilaudid 4 mg q 4 hours prn. The injured worker reported she felt Dilaudid had not been beneficial for severe breakthrough pain. Physical examination revealed exquisite tenderness over the lateral epicondyle of the right elbow, antalgic gait, 1-2+ bilateral lumbar paraspinous tenderness with muscle spasms, decreased lumbar range of motion, positive straight leg raising bilaterally, hypoesthesia in the left greater than right L5 and S1 dermatome. Diagnoses are low back and bilateral lower extremity pain and weakness, lumbar spine sprain/strain status post L4-5 and L5-S1 revision lumbar fusion, bilateral knee

sprain/strain with internal derangement, paroxysmal neuropathic pain with muscle spasms and dystonia, and possible inflammatory/immune response. Treatment plan included prescriptions for Norco, trial of MSIR 15 mg, compounded topical analgesic, and baclofen. Initial request was non-certified on 04/29/14.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Norco 10/325 mg q6h prn #180:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 94.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, page(s) 77 Page(s): 77.

**Decision rationale:** As noted in the Chronic Pain Medical Treatment Guidelines, patients must demonstrate functional improvement in addition to appropriate documentation of ongoing pain relief to warrant the continued use of narcotic medications. There is sufficient documentation regarding the functional benefits and functional improvement obtained with the continued use of narcotic medications. As the clinical documentation provided for review supports an appropriate evaluation for the continued use of narcotics as well as establishes the efficacy of narcotics, Norco 10/325 mg q6h prn #180 is recommended as medically necessary at this time.

**Trial MSIR 15 mg #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, page(s) 77 Page(s): 77.

**Decision rationale:** The documentation indicated the injured worker reported significant pain relief and increased functional improvement with the use of medications without MSIR ER. The medications decreased the pain from 10/10 to 2/10 indicating appropriate pain control. As such, the request for Trial MSIR 15 mg #60 cannot be recommended as medically necessary at this time.

**Trial KGL cream compound:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 112.

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

**Decision rationale:** As noted on page 111 of the Chronic Pain Medical Treatment Guidelines, the safety and efficacy of compounded medications has not been established through rigorous clinical trials. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Further, CAMTUS, Food and Drug Administration, and Official Disability Guidelines require that all components of a compounded topical medication be approved for transdermal use. In addition, there is no evidence within the medical records submitted that substantiates the necessity of a transdermal versus oral route of administration. Therefore Trial KGL cream compound cannot be recommended as medically necessary as it does not meet established and accepted medical guidelines.