

<b>Case Number:</b>	CM14-0189513		
<b>Date Assigned:</b>	11/20/2014	<b>Date of Injury:</b>	07/21/2009
<b>Decision Date:</b>	01/08/2015	<b>UR Denial Date:</b>	10/28/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/13/2014

### 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 Anesthesiology, has a subspecialty in Pain Management 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 50-year-old female with a 7/21/09 date of injury. At the time (10/15/14) of request for authorization for LESI 1-2 times a month for 4 months (epidural steroid injections), 1 Prescription for ThermaCare patch #30, 1 Prescription for Lidocaine patch #30, 1 Prescription for Oxycodone 5 mg #15, 1 Prescription for Ambien 1/2 tab #15, and 1 Prescription for a trial of Dilaudid 2 mg #15, there is documentation of subjective (chronic low back pain with maximum pain in the buttock radiating into the posterior leg Right greater than Left with numbness) and objective decreased range of motion and sharp pain on extension, positive facet loading test on the left, and tenderness to palpation over the L5-S1 paraspinal muscles and the left piriformis muscle) findings, imaging findings (Reported MRI of the lumbar spine (2/21/14) revealed evidence of degenerative changes at the L3-4 disc with minimal central bulging and there is no significant foraminal stenosis; report not available for review), current diagnoses (lumbar disc derangement, lumbar radiculitis, GERD secondary to pain medications, and pain related sleep disorder), and treatment to date (TENS unit, Physical therapy, lumbar epidural steroid injections, and medications (including ongoing treatment with Norco, Ambien, Lidocaine patches, ThermaCare patches, Oxycodone since at least 6/30/14)). Medical reports identify a request for right Transforaminal Epidural injection at L3-L4. Regarding LESI 1-2 times a month for 4 months (epidural steroid injections), there is no documentation of at least 50-70% pain relief for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year, as well as decreased need for pain medications, and functional response as a result of previous epidural injections. Regarding ThermaCare patch #30, there is no documentation of acute or subacute low back pain and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of ThermaCare use to date.

Regarding Lidocaine patch #30, there is no documentation that a trial of first-line therapy (tricyclic or SNRI anti-depressants or an AED such as Gabapentin or Lyrica) has failed and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Lidoderm patch use to date. Regarding Oxycodone 5 mg #15, there is no documentation of moderate to severe pain when a continuous, around-the-clock analgesic is needed for an extended period of time; the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects; and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Oxycodone use to date. Regarding Ambien 1/2 tab #15, there is no documentation of insomnia, short-term (less than two to six weeks) treatment, and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Ambien use to date. Regarding Dilaudid 2 mg #15, there is no documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects.

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

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

**LESI 1-2 times a month for 4 months (epidural steroid injections): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines ESIs Page(s): 49.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Epidural Steroid Injections (ESIs)

**Decision rationale:** MTUS reference to ACOEM guidelines identifies documentations of objective radiculopathy in an effort to avoid surgery as criteria necessary to support the medical necessity of epidural steroid injections. ODG identifies documentation of at least 50-70% pain relief for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year, as well as decreased need for pain medications, and functional response as criteria necessary to support the medical necessity of additional epidural steroid injections. Within the medical information available for review, there is documentation of diagnoses of lumbar disc derangement, lumbar radiculitis, GERD secondary to pain medications, and pain related sleep disorder. In addition, there is documentation of previous lumbar epidural steroid injections and a request for right Transforaminal Epidural injection at L3-L4. However, there is no documentation of at least 50-70% pain relief for six to eight weeks, as well as decreased need for pain medications, and functional response as a result of previous epidural injections. In addition, given the requested LESI 1-2 times a month for 4 months (epidural steroid injections), there is no documentation that no more than 4 blocks per region per year will be injected. Therefore, based

on guidelines and a review of the evidence, the request for LESI 1-2 times a month for 4 months (epidural steroid injections) is not medically necessary.

### **1 Prescription for ThermaCare patch #30: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 288. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, heat therapy

**Decision rationale:** MTUS reference to ACOEM states that relieving discomfort can be accomplished most safely by non-prescription medication or an appropriately selected non-steroidal anti-inflammatory drug (NSAID), appropriate adjustment of activity, and use of thermal modalities such as ice and/or heat. In addition, MTUS reference to ACOEM identifies that at home applications of heat or cold packs may be used before or after exercises and are as effective as those performed by therapists. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. ODG identifies that heating therapy is recommended as an option, that heat wrap therapy provides a small short-term reduction in pain and disability in acute and sub-acute low-back pain, and that the addition of exercise further reduces pain and improves function. Within the medical information available for review, there is documentation of diagnoses of lumbar disc derangement, lumbar radiculitis, GERD secondary to pain medications, and pain related sleep disorder. However, there is no documentation of acute or subacute low back pain. In addition, given documentation of ongoing treatment with ThermaCare, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of ThermaCare use to date. Therefore, based on guidelines and a review of the evidence, the request for 1 Prescription for ThermaCare patch #30 is not medically necessary.

### **1 Prescription for Lidocaine patch #30: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm (lidocaine patch) Page(s): 56-57.

**Decision rationale:** MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of neuropathic pain after there has been evidence that a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica) has failed, as criteria necessary to support the medical necessity of a lidocaine patch. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance;

and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of lumbar disc derangement, lumbar radiculitis, GERD secondary to pain medications, and pain related sleep disorder. In addition, there is documentation of neuropathic pain. However, there is no documentation that a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica) has failed. In addition, given documentation of ongoing treatment with Lidocaine patches, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Lidoderm patch use to date. Therefore, based on guidelines and a review of the evidence, the request for 1 Prescription for Lidocaine patch #30 is not medically necessary.

### **1 Prescription for Oxycodone 5 mg #15: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids; Oxycodone Page(s): 74-80; 92.

**Decision rationale:** MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of moderate to severe pain when a continuous, around-the-clock analgesic is needed for an extended period of time, as criteria necessary to support the medical necessity of Oxycontin. In addition, MTUS Chronic Pain Medical Treatment Guidelines identifies documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects, as criteria necessary to support the medical necessity of Oxycontin. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of lumbar disc derangement, lumbar radiculitis, GERD secondary to pain medications, and pain related sleep disorder. However, there is no documentation of moderate to severe pain when a continuous, around-the-clock analgesic is needed for an extended period of time and the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. In addition, given documentation of ongoing treatment with Oxycodone, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Oxycodone use to date. Therefore, based on guidelines and a review of the evidence, the request for 1 Prescription for Oxycodone 5 mg #15 is not medically necessary.

### **1 Prescription for Ambien 1/2 tab #15: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter, Zolpidem

**Decision rationale:** MTUS does not address this issue. ODG identifies Ambien (zolpidem) as a prescription short-acting non-benzodiazepine hypnotic, which is approved for the short-term (usually two to six weeks) treatment of insomnia. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of lumbar disc derangement, lumbar radiculitis, GERD secondary to pain medications, and pain related sleep disorder. However, despite documentation of a diagnosis of pain related sleep disorder, there is no (clear) documentation of Insomnia. In addition, given documentation of records reflecting prescription for Ambien since at least 6/30/14, there is no documentation of short-term (less than two to six weeks) treatment and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Ambien use to date. Therefore, based on based on guidelines and a review of the evidence, the request for 1 Prescription for Ambien 1/2 tab #15 is not medically necessary.

**1 Prescription for a trial of Dilaudid 2 mg #15: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 79-81, 82-88.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-80.

**Decision rationale:** MTUS Chronic Pain Medical Treatment Guidelines necessitate documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects, as criteria necessary to support the medical necessity of opioids. Within the medical information available for review, there is documentation of diagnoses of lumbar disc derangement, lumbar radiculitis, GERD secondary to pain medications, and pain related sleep disorder. However, there is no documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. In addition, there is no documentation of a rationale for the medical necessity of the requested 1 Prescription for a trial of Dilaudid 2 mg #15. Therefore, based on based on guidelines and a review of the evidence, the request for 1 Prescription for a trial of Dilaudid 2mg #15 is not medically necessary.