

<b>Case Number:</b>	CM14-0205168		
<b>Date Assigned:</b>	12/17/2014	<b>Date of Injury:</b>	09/26/2004
<b>Decision Date:</b>	02/04/2015	<b>UR Denial Date:</b>	11/07/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/08/2014

### 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 Internal Medicine and is licensed to practice in New York. 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 claimant is a 67 yo female who sustained an industrial injury on 09/26/2004. The mechanism of injury was not provided for review. Her diagnoses include chronic low back pain, lumbosacral spondylosis without myelopathy, displacement of the lumbar intervertebral disc without myelopathy, and adjustment disorder with mixed anxiety and depression. She continues to complain of low back pain. Physical exam demonstrated decreased range of lumbar motion, positive straight leg raising, decreased strength in the lower extremities and decreased sensation in the lower extremities. Treatment has consisted of medical therapy with opiates, physical therapy and a home exercise program. The treating provider has requested 12 sessions of Acupuncture to the Lumbar Spine ( 2x 6 weeks), Lidoderm Patch 5% # 30, Norco 10/325mg # 90, Oxycontin 40mg # 90, Physical Therapy to the Lumbar Spine: 12 sessions ( 3x 4 weeks), and a Productivity Enhancement Program ( 3x 4 weeks).

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Twelve sessions of Acupuncture to the Lumbar Spine (2 x 6 weeks): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**Decision rationale:** Per the guidelines, acupuncture is used as an option when pain medication is reduced or not tolerated. It may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten recovery. The MTUS/Acupuncture medical treatment guidelines support acupuncture treatment to begin as an initial treatment of 3-6 sessions over no more than two weeks. If functional improvement is documented as defined by the guidelines further treatment will be considered. In this case, the initial request exceeds the guideline recommendations. Medical necessity for the requested service has not been established. The requested service is not medically necessary.

**Lidoderm 5% patch #30:** 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): 111-113.

**Decision rationale:** There is no documentation provided necessitating use of the requested topical medications. Per California MTUS Guidelines, topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied topically to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control (including NSAIDs, opioids, capsaicin, local anesthetics, antidepressants, glutamate receptor antagonists, alpha-adrenergic receptor agonist, adenosine, cannabinoids, cholinergic receptor agonists, gamma agonists, prostanoids, bradykinin, adenosine triphosphate, biogenic amines, and nerve growth factor). Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. In this case there is no documentation provided necessitating the use of Lidocaine patches. Per California MTUS 2009 Guidelines, Lidoderm is recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tricyclic or SNRI anti-depressants or an anticonvulsant medication such as gabapentin or Lyrica). The medication is only FDA approved for post-herpetic neuralgia. There is no documentation of intolerance to other previous treatments. Medical necessity for the requested topical medications has not been established. The requested treatment is not medically necessary.

**Norco 10/325mg #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 91.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 91-97.

**Decision rationale:** The documentation indicates the enrollee has been treated with opioid therapy using Norco. Per California MTUS Guidelines, short-acting opioids such as Norco are seen as an effective method in controlling chronic pain. They are often used for intermittent or

breakthrough pain. The treatment of chronic pain with any opioid agent requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include current pain: last reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid, and the duration of pain relief. Per the medical documentation, there has been no documentation of the medication's pain relief effectiveness and no clear documentation that the claimant has responded to ongoing opioid therapy. According to the California MTUS Guidelines, there has to be certain criteria followed including an ongoing review and documentation of pain relief and functional status. This does not appear to have occurred with this patient. The patient has continued pain despite the use of long and short acting opioid medications. Medical necessity for Norco 10/325 has not been established. The requested treatment is not medically necessary.

**Oxycontin 40mg #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 91.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 91-97.

**Decision rationale:** The documentation indicates the enrollee has been treated with opioid therapy using Oxycontin 60 mg bid and Oxycodone for breakthrough pain. Per California MTUS Guidelines, Oxycontin is a long acting very potent analgesic that is usually combined with acetaminophen or aspirin. Short-acting opioids are seen as an effective method in controlling chronic pain. They are often used for intermittent or breakthrough pain. The treatment of chronic pain with any opioid agent requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include current pain: last reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid, and the duration of pain relief. Per the medical documentation, there has been no documentation of the medication's pain relief effectiveness and no clear documentation that he has responded to ongoing opioid therapy. According to the California MTUS Guidelines, there has to be certain criteria followed including an ongoing review and documentation of pain relief and functional status. This does not appear to have occurred with this patient. The patient has continued pain despite the use of long and short acting opioid medications. The requested treatment is not medically necessary.

**Twelve sessions of Physical Therapy to the lumbar spine (3 x 4 weeks):** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98.

**Decision rationale:** Per California MTUS Treatment Guidelines 2009, physical therapy is indicated for the treatment of chronic low back pain. Recommendations state that for most

patients with more severe acute and subacute low back pain conditions, 8 to 12 visits over a period of over 6 to 8 weeks is indicated as long as functional improvement and program progression are documented. Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. In this case, the claimant has completed physical therapy sessions with a reported good benefit and she is participating in a home exercise program. There is no specific indication for additional physical therapy sessions. Medical necessity for the requested additional physical therapy sessions has not been established. The requested services are not medically necessary.

**Productivity Enhancement Program (3 x 4 weeks): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Work Conditioning Page(s): 125.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 125.

**Decision rationale:** Per MTUS, criteria for admission to a Work Hardening Program:(1) Work related musculoskeletal condition with functional limitations precluding ability to safely achieve current job demands, which are in the medium or higher demand level (i.e., not clerical/sedentary work). An FCE may be required showing consistent results with maximal effort, demonstrating capacities below an employer verified physical demands analysis (PDA).(2) After treatment with an adequate trial of physical or occupational therapy with improvement followed by plateau, but not likely to benefit from continued physical or occupational therapy, or general conditioning.(3) Not a candidate where surgery or other treatments would clearly be warranted to improve function.(4) Physical and medical recovery sufficient to allow for progressive reactivation and participation for a minimum of 4 hours a day for three to five days a week.(5) A defined return to work goal agreed to by the employer & employee:(a) A documented specific job to return to with job demands that exceed abilities, OR (b) Documented on-the-job training(6) The worker must be able to benefit from the program (functional and psychological limitations that are likely to improve with the program). Approval of these programs should require a screening process that includes file review, interview and testing to determine likelihood of success in the program.(7) The worker must be no more than 2 years past date of injury. Workers that have not returned to work by two years post injury may not benefit.(8) Program timelines: Work Hardening Programs should be completed in 4 weeks consecutively or less.(9) Treatment is not supported for longer than 1-2 weeks without evidence of patient compliance and demonstrated significant gains as documented by subjective and objective gains and measurable improvement in functional abilities.(10) Upon completion of a rehabilitation program (e.g. work hardening, work conditioning, outpatient medical rehabilitation) neither re-enrollment in nor repetition of the same or similar rehabilitation program is medically warranted for the same condition or injury. The review has determined that the guideline criteria have not been met. The claimant's complaints of low back pain have been present for greater than 2 years. In addition,

the claimant is still undergoing active medical and physical therapy for her chronic pain condition. Medical necessity for the requested item has not been established. The request is not medically necessary.