

<b>Case Number:</b>	CM15-0007115		
<b>Date Assigned:</b>	01/26/2015	<b>Date of Injury:</b>	09/17/2010
<b>Decision Date:</b>	03/20/2015	<b>UR Denial Date:</b>	12/31/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/13/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 50 year old male, who sustained an industrial injury on September 17, 2010. He has reported lower back pain radiating to the left leg and left leg weakness. The diagnoses have included lumbar spine sprain/strain, displacement of lumbar intervertebral disc, degeneration of lumbar or lumbosacral intervertebral disc, lumbar postlaminectomy syndrome, and depression. Treatment to date has included medications, use of a cane and walker, lower back surgery, and radio frequency rhizotomy. Currently, the injured worker complains of increasing lower back pain with radiation to the left leg and left leg weakness. The treating physician is requesting prescriptions for Norco, Oxycodone and Voltaren gel to treat the injured worker's pain. On December 31, 2014 Utilization Review non-certified the request for the prescriptions noting the lack of documentation to support the medical necessity of the medications. The MTUS was cited in the decision.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**NORCO 10/325 #90:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines  
CRITERIA FOR USE OF OPIOIDS Page(s): 76-78, 88-89.

**Decision rationale:** Per the 12/23/14 report the patient presents with constant progressive left lower back pain with left lower extremity weakness and pain to the left foot s/p back surgery 2011. He has a history of SI joint dysfunction. The current request is for NORCO 10/325 #90 Hydrocodone, an opioid. The RFA is not included. The 12/31/14 utilization review states the provider request is dated 12/23/14. As of 11/24/14 the patient is working a 40 hour week. MTUS Guidelines pages 88 and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4As (analgesia, ADLs, adverse side effects, and adverse behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. The reports provided show the patient was prescribed this medication from 01/06/14 to 12/23/14. The 12/23/14 report states the medication is discontinued and Oxycodone "an opioid" is started. The 11/24/14 report states pain medications reduce pain 30% with pain at 10/10 without medications and 7-8/10 with. ADL's are documented. The patient is working full time and the reports state medication allows the patient to complete daily activities such as walking, shopping and light household chores. However, opiate management issues are not fully documented. No urine toxicology reports are provided for review or discussed. Side effects are mentioned as medication induces some stomach indigestion. Adverse behavior is not discussed. There is no mention of CURES. No outcome measures are provided. In this case, opiate management issues have not been sufficiently documented to support long-term opioid use. The request IS NOT medically necessary.

**OXYCODONE 10 MG #100:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines  
CRITERIA FOR USE OF OPIOIDS Page(s): 76-78, 88-89.

**Decision rationale:** Per the 12/23/14 report the patient presents with constant progressive left lower back pain with left lower extremity weakness and pain to the left foot s/p back surgery 2011. He has a history of SI joint dysfunction. The current request is for OXYCODONE 10 mg #100, an opioid--per the RFA of 12/23/14. As of 11/24/14 the patient is working a 40 hour week. MTUS Guidelines pages 88 and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4As (analgesia, ADLs, adverse side effects, and adverse behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. The reports provided for review show the patient has been prescribed an opioid "Norco" since at least 01/06/14. The patient is just

starting this medication and discontinuing Norco on 12/23/14. The 11/24/14 report states pain medications reduce pain 30% with pain at 10/10 without medications and 7-8/10 with. ADL's are documented. The patient is working full time and the reports state medication allows the patient to complete daily activities such as walking, shopping and light household chores. However, opiate management issues are not documented. No urine toxicology reports are provided for review or discussed. Side effects are documented as medication induces some stomach indigestion. Adverse behavior is not discussed. There is no mention of CURES. No outcome measures are provided. In this case, opiate management issues have not been sufficiently documented to support long-term opioid use. The request IS NOT medically necessary.

**VOLTAREN GEL 1 TUBE:** 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 analgesic Page(s): 111-113.

**Decision rationale:** Per the 12/23/14 report the patient presents with constant progressive left lower back pain with left lower extremity weakness and pain to the left foot s/p back surgery 2011. He has a history of SI joint dysfunction. The current request is for VOLTAREN GEL 1 TUBE an NSAID. As of 11/24/14 the patient is working a 40 hour week. MTUS page 111 of the chronic pain section states the following regarding topical analgesics: "Largely experimental in use with few randomized controlled trials to determine efficacy or safety." "There is little to no research to support the use of many of these agents." Topical NSAIDs are indicated for peripheral joint arthritis/tendinitis. The reports provided for review show the patient is starting this medication on 12/23/14. In this case, Voltaren gel is indicated for peripheral joint arthritis/tendinitis which is not documented for this patient. Lacking recommendation by guidelines, the request IS NOT medically necessary.