

<b>Case Number:</b>	CM15-0137309		
<b>Date Assigned:</b>	07/27/2015	<b>Date of Injury:</b>	11/24/2010
<b>Decision Date:</b>	08/31/2015	<b>UR Denial Date:</b>	07/02/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/15/2015

### 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, Hawaii

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 59 year old male, who sustained an industrial injury on November 24, 2010, incurring right hip injuries. She was diagnosed with right hip osteoarthritis, and right hip internal derangement. Treatment included pain medications, physical therapy, home exercise program, and activity restrictions. She underwent a total right hip replacement. Currently, the injured worker complained of chronic right hip, right low back and right buttock pain. The pain was aggravated with prolonged sitting, prolonged standing, lifting, twisting and any activities. Decreased range of motion of the lower right extremity and lower back was noted upon examination. The treatment plan that was requested for authorization included prescriptions for Norco, Prozac and a request for a closed Magnetic Resonance Imaging of the lumbar spine.

### IMR ISSUES, DECISIONS AND RATIONALES

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

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

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96.

**Decision rationale:** According to the most recent attending physician report dated 6/23/15, the patient has increasing low back pain radiating to the right buttock, right posterolateral thigh and right calf. The current request is for Norco 10/325mg #90. The attending physician states in his 6/23/15 attending physician report page 170 (b), that the Norco decreases pain by 70% and improves ADLs by 70%. He also notes that the patient has an up to date pain contract. There is additional mention of previous UDS which is consistent, and denies any adverse effects and no aberrant behaviors. According to the MTUS guidelines, four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids. The domains have been summarized as the 4 A's (analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. In this case, there is clear documentation of the 4 A's. There is decreased pain and documentation of improved functional ability. It is also documented that there has been no adverse side effects or aberrant drug behaviors. The current medical records do support medical necessity for the request of Norco.

**Prozac 20mg #90 with 5 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 13.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-depressants for Chronic Pain Page(s): 13.

**Decision rationale:** According to the most recent attending physician report dated 6/23/15, the patient has increasing low back pain radiating to the right buttock, right posterolateral thigh and right calf. The current request is for Prozac 20mg #90 with 5 refills. The attending physician report dated June 23, 2015 does not address symptoms of depression. The physician states the patient was unable to fill the prescription for the prescribed Prozac in his 6/23/15 report. He does not note depression in the diagnoses section of his report. The MTUS guidelines state that antidepressants are recommended as a first line option for neuropathic pain, and as a possibility for non-neuropathic pain. (Feuerstein, 1997) (Perrot, 2006) Tricyclics are generally considered a first-line agent unless they are ineffective, poorly tolerated, or contraindicated. Analgesia generally occurs within a few days to a week, whereas antidepressant effect takes longer to occur. (Saarto-Cochrane, 2005) Assessment of treatment efficacy should include not only pain outcomes, but also an evaluation of function, changes in use of other analgesic medication, sleep quality and duration, and psychological assessment. Side effects, including excessive sedation (especially that which would affect work performance) should be assessed. In this case, the records indicate decreased pain and improved ADLs with the medications. Records also indicate no adverse drug behavior or aberrant behavior. However, this request states that the patient requires 5 refills and MTUS on page 60 requires monitoring of the patient's pain and function with chronic usage of pain medications. The request for Prozac with 5 refills is not medically necessary.

**Closed MRI lumbar spine:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96.

**Decision rationale:** According to the most recent attending physician report dated 6/23/15, the patient has increasing low back pain radiating to the right buttock, right posterolateral thigh and right calf. The current request is for closed MRI lumbar spine. The attending physician recommends closed MRI lumbar spine to evaluate for nerve root impingement, disc protrusion, stenosis, degenerative disc disease, and facet joint arthropathy. The MTUS guidelines do not address lumbar spine MRI scans. The ODG guidelines lumbar chapter recommends MRI scans for patients with lower back pain with radiculopathy, suspicion of cancer, infection and other red flags. The attending physician in this case has indicated that the patient has continued lower back pain with right lower extremity radicular pain with a positive straight leg raise test. There is no indication that the patient has previously received a lumbar MRI. The current request is medically necessary.