

<b>Case Number:</b>	CM15-0165952		
<b>Date Assigned:</b>	09/03/2015	<b>Date of Injury:</b>	08/21/2008
<b>Decision Date:</b>	10/22/2015	<b>UR Denial Date:</b>	07/27/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/24/2015

### 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, Pain Management

### 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 was a 53 year old male, who sustained an industrial injury, August 21, 2008. The injured worker previously received the following treatments Lyrica, Voltaren Gel, Oxycodone 10 mg and Oxycontin 40 mg. The injured worker was diagnosed with post laminectomy syndrome of the lumbar spine, thoracic and lumbosacral neuritis and radiculopathy, spinal stenosis lumbar spine without neurogenic claudication, insomnia, esophageal reflux disease, chronic pain syndrome, spondylosis of non-specified site without myelopathy, long term use of (current) use of other medications and sacrolitis. According to progress note of April 24, 2015, the injured worker's chief complaint was low back pain, mid back pain, shoulder, neck and bilateral leg pain. The severity of the pain was moderate to horrible. Modifying factors were improvement with changing positions, improvement with sitting and medications. The associated symptoms were stiffness, swelling, weakness, tenderness and hypersensitivity. The cervical spine and thoracic spine noted no pain with range of motion. The examination of the lumbar spine noted limited range of motion and stiffness and tenderness with palpation. The flexion, extension were decreased range of motion with pain. There was tenderness over the bilateral lumbar paraspinous muscles, bilateral sacroiliac joints, midline and lumbar region and lumbar facet. There was tenderness in the left medius gluteus. The injured worker walked with a normal gait. The injured worker reported balance problems with walking and climbing. There was decrease sensation at the L5 and S1 dermatomes. The injured worker reported to have better pain control with Lyrica, Voltaren Gel, Oxycodone 10 mg and Oxycontin 40 mg with no adverse reactions. The treatment plan included prescriptions renewals for Voltaren 1% Gel, Oxycodone 10 mg and

Oxycontin 40 mg, urine toxicology screen and bilateral sacroiliac joint injections under fluoroscopy.

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

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

**Voltaren 1% gel, Qty 5 tubes:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines - Pain - Diclofenac (Voltaren gel).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

**Decision rationale:** Regarding the request for Voltaren gel, guidelines state that topical NSAIDs are recommended for short-term use. Oral NSAIDs contain significantly more guideline support, provided there are no contraindications to the use of oral NSAIDs. Within the documentation available for review, there's no indication that the patient has obtained any specific analgesic effect (in terms of percent reduction in pain, or reduced NRS) or specific objective functional improvement from the use of Voltaren gel. Additionally, there is no documentation that the patient would be unable to tolerate oral NSAIDs, which would be preferred, or that the Voltaren is for short-term use, as recommended by guidelines. In the absence of clarity regarding those issues, the currently requested Voltaren gel is not medically necessary.

**Oxycodone 10 mg Qty 150:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines - Pain - Opioids for chronic pain.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids (Classification), Opioids, California Controlled Substance Utilization Review and Evaluation System (CURES) [DWC], Opioids, criteria for use, Opioids for chronic pain, Opioids for neuropathic pain, Opioids for osteoarthritis, Opioids, cancer pain vs. nonmalignant pain, Opioids, dealing with misuse & addiction, Opioids, differentiation: dependence & addiction, Opioids, dosing, Opioids, indicators for addiction, Opioids, long-term assessment.

**Decision rationale:** Regarding the request for oxycodone (Roxicodone), California Pain Medical Treatment Guidelines state that this is an opiate pain medication. Due to high abuse potential, close follow-up is recommended with documentation of analgesic effect, objective functional improvement, side effects, and discussion regarding any aberrant use. Guidelines go on to recommend discontinuing opioids if there is no documentation of improved function and pain. Within the documentation available for review, there is no indication that the medication is improving the patient's function or pain (in terms of specific examples of functional

improvement and percent reduction in pain or reduced NRS). As such, there is no clear indication for ongoing use of the medication. Opioids should not be abruptly discontinued, but unfortunately, there is no provision to modify the current request to allow tapering. In light of the above issues, the currently requested oxycodone (Roxicodone) is not medically necessary.

**Urine toxicology screen:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, screening for risk of addiction (tests), Opioids, specific drug list, Opioids, steps to avoid misuse/addiction.

**Decision rationale:** Regarding the request for a urine toxicology test (UDS), CA MTUS Chronic Pain Medical Treatment Guidelines state the drug testing is recommended as an option. Guidelines go on to recommend monitoring for the occurrence of any potentially aberrant (or non-adherent) drug related behaviors. ODG recommends urine drug testing on a yearly basis for low risk patients, 2-3 times a year for moderate risk patients, and possibly once per month for high risk patients. Within the documentation available for review, it appears the patient is on controlled substance medication. Additionally, there is no identification of a recent urine drug screen. As such, the currently requested urine toxicology test is medically necessary.

**Bilateral Sacroiliac Joint injection, under fluoroscopy:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines: Hip & Pelvis - Sacroiliac joint blocks.

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Initial Assessment, Diagnostic Criteria, Initial Care. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hip and Pelvis Chapter, Sacroiliac Injections (Diagnostic/Therapeutic).

**Decision rationale:** Regarding the request for sacroiliac joint injections, guidelines state that sacroiliac injections (diagnostic/therapeutic) are not recommended. Within the documentation available for review, there are no peer-reviewed studies provided, of sufficient power to overturn guideline recommendation against the use of this procedure. As such, the currently requested sacroiliac joint injections are not medically necessary.