

<b>Case Number:</b>	CM15-0168623		
<b>Date Assigned:</b>	09/09/2015	<b>Date of Injury:</b>	08/02/2002
<b>Decision Date:</b>	10/26/2015	<b>UR Denial Date:</b>	08/10/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/27/2015

### 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: Preventive Medicine, Occupational Medicine

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This injured worker is a 44 year old female, who sustained an industrial injury on 08-02-2002. The injured worker was diagnosed as having lumbar or lumbosacral disc degeneration, labral tear-hip-right, mood disorder and sacroiliac pain. On medical records dated 08-03-2015 and 07-06-2015 the subjective findings revealed lower backache. Pain was medication was noted at 7 out of 10 and without medications 10 out of 10. Activity level was noted to remain the same and was able to perform her activities of daily living and increase her activity with medication. Objective findings were noted as having an antalgic gait; lumbar spine paravertebral muscles were noted to have tenderness and tight muscles band on palpation. Lumbar facet loading was negative as well as straight leg raise. Tenderness was noted on right SI joint to palpation. Left shoulder movement was restricted due to pain and tenderness to genohumeral joint and subdeltoid bursa was noted. Right hip range of motion was restricted with tenderness over the groin. Right knee range of motion was restricted with tenderness over the medial joint line and 1+ effusion in the right knee joint. Left knee was noted to have tenderness to palpation noted as generalized. The injured worker was working full time. Treatments to date included medication and physical therapy. Current medication included Omeprazole Dr, Oxycodone, OxyContin, Trazadone and Gabapentin. The injured worker was noted to be on Oxycodone, OxyContin, Trazadone and Gabapentin at least since 09-10-2014. The Utilization Review (UR) dated 08-10-2015, was noted to have a Request for Authorization dated 08-03-2015. The UR submitted for this medical review indicted that the request for Lidoderm 5% patch qty 30 was non-certified, Oxycodone 30 mg qty 120 was non-certified, OxyContin ER 80mg qty 90 was non-certified,

Trazodone 150mg qty 30 was non-certified, Gabapentin 300mg qty 120 was non-certified and Omeprazole DR 20mg qty 60 was non-certified.

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

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

#### **Lidoderm 5% patch qty 30: Upheld**

**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): Topical Analgesics.

**Decision rationale:** According to the MTUS, Lidoderm may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). This is not a first-line treatment and is only FDA approved for post-herpetic neuralgia. The medical record has no documentation that the patient has undergone a trial of first-line therapy. Lidoderm 5% patch qty 30 is not medically necessary.

#### **Oxycodone 30 mg qty 120: Upheld**

**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 for chronic pain.

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines state that continued or long-term use of opioids should be based on documented pain relief and functional improvement or improved quality of life. Despite the long-term use of Norco, the patient has reported very little, if any, functional improvement or pain relief. The patient has been taking Oxycodone for at least as far back as 18 months and reported only a minimal reduction in pain levels, from a 10/10 to an 8/10. Oxycodone 30 mg qty 120 is not medically necessary.

#### **Oxycontin ER 80mg qty 90: Upheld**

**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 for chronic pain.

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines state that continued or long-term use of opioids should be based on documented pain relief and functional improvement or improved quality of life. Despite the long-term use of Norco, the patient

has reported very little, if any, functional improvement or pain relief. The patient has been taking Oxycodone for at least as far back as 18 months and reported only a minimal reduction in pain levels, from a 10/10 to an 8/10. Oxycodone 30 mg qty 120 is not medically necessary.

**Trazodone 150mg qty 30: Upheld**

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Pain (Chronic), Antidepressants for chronic pain.

**Decision rationale:** Trazodone is a tetracyclic antidepressant used to treat depression and anxiety disorders. The Official Disability Guidelines recommend numerous antidepressants in a number of classes for treating depression and chronic pain. Trazodone is not contained within the current recommendations by the ODG. Trazodone 150mg qty 30 is not medically necessary.

**Gabapentin 300mg qty 120: Upheld**

**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): Antiepilepsy drugs (AEDs).

**Decision rationale:** The MTUS states that gabapentin is an anti-epilepsy drug, which has been shown to be effective for treatment of diabetic painful neuropathy and post herpetic neuralgia and has been considered as a first-line treatment for neuropathic pain. An adequate trial period for gabapentin is three to eight weeks for titration, then one to two weeks at maximum tolerated dosage. With each office visit, the patient should be asked if there has been a change in the patient's pain symptoms, with the recommended change being at least 30%. There is no documentation of any functional improvement. Gabapentin 300mg qty 120 is not medically necessary.

**Omeprazole DR 20mg qty 60: Upheld**

**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): NSAIDs, GI symptoms & cardiovascular risk.

**Decision rationale:** According to the Chronic Pain Medical Treatment Guidelines, prior to starting the patient on a proton pump inhibitor, physicians are asked to evaluate the patient and to determine if the patient is at risk for gastrointestinal events. Criteria used are: (1) age > 65 years;

(2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID. There is no documentation that the patient has any of the risk factors needed to recommend the proton pump inhibitor omeprazole. Omeprazole DR 20mg qty 60 is not medically necessary.