

<b>Case Number:</b>	CM15-0021996		
<b>Date Assigned:</b>	02/09/2015	<b>Date of Injury:</b>	06/01/2000
<b>Decision Date:</b>	03/25/2015	<b>UR Denial Date:</b>	01/09/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/05/2015

### 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: Arizona, California  
 Certification(s)/Specialty: Family Practice

### 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 64 year old male, who sustained an industrial injury, June 10, 2000. According to progress note of December 12, 2014, the injured workers chief complaint was lower back pain. The injured workers pain level was 6 out of 10 with pain medication and 9 out of 10 without pain medication; 0 being no pain and 10 being the worse pain. The physical exam noted limited range of motion to the lumbar spine without pain. The injured worker cannot do heel to toe walking and was limited to weight bearing on the left leg only. Lumbar facet loading was positive on the right side. There was tenderness noted over the sacroiliac spine. There was decreased sensation to the right lateral leg. The injured worker was diagnosed with post lumbar laminectomy Syndrome and lumbar radiculopathy. The injured worker previously received the following treatments random toxicology screening, one Lidoderm patch daily, Neurontin 800mg 3 times a day, Dilaudid 4mg 4 times daily, Duragesic 50mcg/hour Patch one patch every 2 days, Carisoprodol 350mg 1 times a day, Ativan 1mg 3 times a day, Xifaxan 550mg 3 times daily and Zanaflex 4 mg t times a day. In November 2014, the claimant had reduced the Dilaudid 50%. On December 12, 2014, the primary treating physician requested authorization for prescriptions for Dilaudid 4mg #120, Duragesic 50mcg/hour patches #15, Lidoderm patches and X-ray of the lumbar spine. On January 9, 2015, the Utilization Review denied authorization for prescriptions for Dilaudid 4mg #120, Duragesic 50mcg/hour patches #15, Lidoderm patches and X-ray of the lumbar spine. The denial was based on the MTUS/ACOEM and ODG guidelines.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Dilaudid 4mg #120: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 82-92.

**Decision rationale:** Dilaudis is a short-acting opioid. According to the MTUS guidelines, it is not indicated as 1st line therapy for neuropathic pain, and chronic back pain . It is not indicated for mechanical or compressive etiologies. It is recommended for a trial basis for short-term use. Long Term-use has not been supported by any trials. In this case, the claimant had been on Dilaudid since atleast 2008. Recently, the claimant required less Duragesic. There was no indication of trial of lower frequency of Dilaudid or an Tylenol/NSAID failure for breakthrough pain. The continued use of Dilaudid is not medically necessary.

**Duragesic 50mcg/hr patch #15: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Duragesic (Fentanyl Transdermal System).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Fentanyl/Duragesic Page(s): 47.

**Decision rationale:** According to the guidelines, Duragesic is an opioid analgesic with a potency eighty times that of morphine. Fentanyl is not recommended as a first-line therapy. The FDA-approved product labeling states that Fentanyl is indicated in the management of chronic pain in patients who require continuous opioid analgesia for pain that cannot be managed by other means. In this case, the claimant had been using Duragesic for over 7 years. Recently, the claimant was requiring less amount of Duragesic. There was no mention of instituting a weaning protocol or a trial of a long acting oral opioid. In addition, the pain scores were stable within the last 6 months likely suggesting tolerance. The continued and long-term use of Duragesic is not medically necessary.

**Unknown prescription of Lidoderm: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm (Lidocaine Patch).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines topical analgesics Page(s): 111-112.

**Decision rationale:** According to the MTUS guidelines, topical analgesics are recommended as an option as indicated below. They are largely experimental in use with few randomized

controlled trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Lidocaine is 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). Lidoderm has been designated for orphan status by the FDA for neuropathic pain. Lidoderm is also used off-label for diabetic neuropathy. In this case the claimant did not have the above diagnoses. Long-term use of topical analgesics such as Lidoderm patches are not recommended. The request for continued and long-term use of Lidoderm patches as above is not medically necessary.

**1 x-ray of the lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 309.

**Decision rationale:** According to the guidelines, a lumbar x-ray is not recommended for routine use in the absence of red flag findings such as fracture or infection. In this case, the injury was 15 years ago. There were no recent findings suggestive of a new injury of red flag. In addition, the claimant had prior MRIs of the lumbar spine and CT indicating post-fusion and degenerative changes. As a result the request for an x-ray is not medically necessary.