

<b>Case Number:</b>	CM15-0027237		
<b>Date Assigned:</b>	02/19/2015	<b>Date of Injury:</b>	09/03/2002
<b>Decision Date:</b>	04/07/2015	<b>UR Denial Date:</b>	01/13/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/12/2015

### 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: Texas, Illinois

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:

The injured worker is a 73 year old female, who sustained an industrial injury on September 3, 2002. The injured worker has reported low back pain. The diagnoses have included lumbago, lumbosacral spondylosis without myelopathy and displacement lumbar intervertebral disc without myelopathy. Treatment included medications, a heating pad and stretching. Most current documentation dated May 1, 2014 notes that the injured worker complained of low back pain with posterior right leg numbness to the foot. The injured worker reported improvement in the pain levels with the current medications. The medications allow for significant improvement with activities of daily living, mobility and sleep. Physical examination of the lumbar spine revealed tenderness of the paraspinal area at the lumbar four level and a decreased range of motion. Straight leg raise was negative bilaterally. On January 13, 2015 Utilization Review non-certified a request for Norco 10/325 mg # 90, Lidoderm 5 % # 30 and a right lumbar three-lumbar four epidural steroid injection. The MTUS, Chronic Pain Medical Treatment Guidelines, were cited.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Norco 10/325 mg, ninety count with no refills:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for the Use of Opioids.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78.

**Decision rationale:** The injured worker sustained a work related injury on September 3, 2002. The medical records provided indicate the diagnosis of lumbago, lumbosacral spondylosis without myelopathy and displacement lumbar intervertebral disc without myelopathy. Treatment included medications, a heating pad and stretching. The medical records provided for review do indicate a medical necessity for Norco 10/325 mg, ninety count with no refills. The records indicate she has moderately severe pain, there is marked improvement in pain and functional activity with the use of the medication, she has no side effect to the medication, prescription sf from one source, she is adhering to the opioid agreement, she is being monitored for abuse/illegal use and there is no evidence of diversion. The records indicate the management is in compliance with the guideline recommendation of the MTUS on maintenance treatment with opioids. The request IS medically necessary.

**Menthoderm 5%, thirty count with no refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Section.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

**Decision rationale:** The injured worker sustained a work related injury on September 3, 2002. The medical records provided indicate the diagnosis of lumbago, lumbosacral spondylosis without myelopathy and displacement lumbar intervertebral disc without myelopathy. Treatment included medications, a heating pad and stretching. The medical records provided for review do not indicate a medical necessity for Mentoderm 5%, thirty count with no refills. The MTUS recommends against the use of any topical analgesic that contains a non-recommendation agent. Mentoderm is a compounded topical analgesic containing methyl salicylate and menthol. Menthol is a non recommended agent. The request IS NOT medically necessary.

**Right L3-L4 epidural steroid injection:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs) Page(s): 46.

**Decision rationale:** The injured worker sustained a work related injury on September 3, 2002. The medical records provided indicate the diagnosis of lumbago, lumbosacral spondylosis without myelopathy and displacement lumbar intervertebral disc without myelopathy. Treatment

included medications, a heating pad and stretching. The medical records provided for review do not indicate a medical necessity for Right L3-L4 epidural steroid injection. The request IS NOT medically necessary.