

<b>Case Number:</b>	CM15-0034994		
<b>Date Assigned:</b>	03/03/2015	<b>Date of Injury:</b>	03/06/2013
<b>Decision Date:</b>	04/20/2015	<b>UR Denial Date:</b>	02/02/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/24/2015

### 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, Arizona  
 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 42-year-old male who reported an injury on 03/06/2013. The mechanism of injury was not stated. The current diagnosis is lumbar radiculopathy. The injured worker presented on 02/17/2015 for a followup evaluation. It was noted that the injured worker had been utilizing gabapentin, naproxen, and Norco. The injured worker underwent an EMG/NCS on 11/13/2014, which reportedly revealed left L5-S1 radiculopathy. The injured worker had been previously treated with physical therapy, chiropractic treatment and medication. The injured worker presented with complaints of low back pain with left lower extremity radiating symptoms. The associated symptoms included numbness, tingling, and weakness of the left lower extremity. Upon examination, there was 4/5 motor weakness on the left, decreased sensation to light touch of the left posterolateral leg, full range of motion of the lumbar spine, pain with extension, flexion, rotation and lateral rotation. Straight leg raise test was positive on the left. Recommendations included continuation of the current medication regimen as well as a left L5-S1 transforaminal epidural steroid injection. A request for authorization form was then submitted on 02/20/2015.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Norco 5/325 mg daily as needed, quantity unspecified qty: 1.00: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 48, 80-81.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

**Decision rationale:** The California MTUS Guidelines state therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. In this case, the injured worker has continuously utilized the above medications for an unknown duration. There is no documentation of objective functional improvement. The injured worker continues to report persistent pain with radiating symptoms into the left lower extremity. There was no documentation of a written consent or agreement for chronic use of an opioid. There was also no documentation of previous urine toxicology reports with evidence of injured worker compliance and nonaberrant behavior. The request as submitted failed to indicate an adequate quantity. As such, the request is not medically appropriate.

**Neurosurgery consultation qty: 1.00:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Occupational Medicine Practice Guidelines, 2nd Edition, 2004, Chapter 7, page 127.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 89-92.

**Decision rationale:** The California MTUS /ACOEM Practice Guidelines state a referral may be appropriate if the practitioner is uncomfortable with the line of inquiry, with treating a particular cause of delayed recovery, or has difficulty obtaining information or an agreement to a treatment plan. In this case, there is no indication that this injured worker is currently a surgical candidate. There is no documentation of the injured worker's response to the previously ordered epidural injection. As the medical necessity has not been established, the request is not medically appropriate at this time.

**Trazodone of unspecified dose and quantity qty: 1.00:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness & Stress Chapter, Trazodone (Desyrel).

**Decision rationale:** The Official Disability Guidelines recommend trazodone as an option for insomnia only for patients with potentially coexisting mild psychiatric symptoms such as

depression or anxiety. There is no documentation of chronic insomnia. There is also no documentation of associated psychological symptoms such as depression or anxiety. Given the above, the medical necessity has not been established in this case. There is no strength, frequency, or quantity listed in the request. Given the above, the request is not medically appropriate.

**Setraline of unspecified dose and quantity qty: 1.00: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 107.

**Decision rationale:** The California MTUS Guidelines state SSRIs are not recommended as a treatment for chronic pain, but may have a role in treating secondary depression. The injured worker does not maintain a diagnosis of depression. Therefore, the medical necessity for the requested medication has not been established in this case. There is also no strength, frequency, or quantity listed. Given the above, the request is not medically appropriate.

**Remeron of unspecified dose and quantity qty: 1.00: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 13-16. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter, Insomnia Treatment.

**Decision rationale:** The California MTUS Guidelines recommend antidepressants as a first line option for neuropathic pain and is a possibility for non-neuropathic pain. Tricyclics are considered a first line agent unless they are ineffective, poorly tolerated, or contraindicated. In this case, the injured worker does not maintain a diagnosis of depression. The medical necessity for an antidepressant has not been established. There is also no frequency, strength, or quantity listed. As such, the request is not medically appropriate.

**Omeprazole 20mg of unspecified quantity qty: 1.00: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines non-steroidal anti inflammatory drugs (NSAIDs) Page(s): 68-69.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68-69.

**Decision rationale:** The California MTUS Guidelines state proton pump inhibitors are recommended for patients at intermediate or high risk for gastrointestinal events. Patients with

no risk factor and no cardiovascular disease do not require the use of a proton pump inhibitor, even in addition to a nonselective NSAID. There is no documentation of cardiovascular disease or increased risk factors for gastrointestinal events. Therefore, the medical necessity for the requested medication has not been established in this case. There is also no frequency or quantity listed. As such, the request is not medically appropriate.

**Lidoderm patch of unspecified quantity qty: 1.00:** Upheld

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

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

**Decision rationale:** The California MTUS Guidelines recommend lidocaine for neuropathic pain or a localized peripheral pain when there is evidence of a failure of first line treatment. In this case, there was no documentation of a failure of antidepressants or anticonvulsants prior to the initiation of a topical analgesic. There is also no strength, frequency, or quantity listed. As such, the request is not medically appropriate.