

<b>Case Number:</b>	CM14-0093678		
<b>Date Assigned:</b>	09/12/2014	<b>Date of Injury:</b>	07/30/2007
<b>Decision Date:</b>	10/16/2014	<b>UR Denial Date:</b>	06/17/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/20/2014

### 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. The expert reviewer is Board Certified in Anesthesiologist, has a subspecialty in Pain Medicine and is licensed to practice in Florida. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 67-year-old male who reported an injury on 07/30/2007. The mechanism of injury was not submitted for clinical review. The diagnoses included spinal stenosis, muscle spasms, neck pain, and carpal tunnel syndrome, chronic pain due to trauma, cervical radiculopathy, insomnia and depression. The previous treatments included medication. In the clinical note dated 06/04/2014 it was reported the injured worker complained of neck pain. He complained of bilateral lateral neck, bilateral posterior neck and left arm pain. It was reported the pain radiated to the left arm and he described the pain as aching, burning, discomfort, piercing and sharp in nature. He rated his pain 8/10 in severity without medication. Upon the physical examination the provider noted the injured worker had tenderness at the cervical root, left shoulder, left arm, facet and trapezius. The provider indicated the injured worker had decreased range of motion. The provider requested Lyrica for severe neuropathic pain, Oxycodone for pain and physical therapy. The Request for Authorization submitted and dated on 06/04/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Lyrica 100mg #180 with 4 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs Page(s): 16,19.

**Decision rationale:** The request for Lyrica 100mg #180 with 4 refills is not medically necessary. The California Medical Treatment Utilization Schedule (MTUS) Guidelines recommend Lyrica for neuropathic pain due to nerve damage. The guidelines note Lyrica has been documented to be effective in the treatment of diabetic neuropathy and postherpetic neuralgia and has FDA approval for both indications, and is considered a first line treatment for both. The guidelines note the medication also has an antianxiety effect. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. Therefore, the request is not medically necessary.

**Oxycodone HCL 15mg #165:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Oxycodone Criteria for continued opioid use.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use, On-Going Management, Page(s): 78.

**Decision rationale:** The request for Oxycodone HCL 15mg #165 is not medically necessary. The California Medical Treatment Utilization Schedule (MTUS) Guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects. The guidelines recommend the use of a urine drug screen or inpatient treatment with issues of abuse, addiction or poor pain control. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. Additionally, the use of a urine drug screen was not provided for clinical review. Therefore, the request is not medically necessary.

**Physical Therapy Sessions (unspecified quantity):** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy(PT)Physical Medicine Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

**Decision rationale:** The request for Physical Therapy Sessions (unspecified quantity) is not medically necessary. The California Medical Treatment Utilization Schedule (MTUS) Guidelines state that active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function and range of motion. The guidelines allow for the fading of treatment frequency plus active self-directed home physical medicine. The guidelines note that for neuralgia and myalgia, 8 to 10 visits of physical therapy are recommended. There is lack of documentation indicating the injured worker's prior

course of physical therapy as well as the efficacy of the prior therapy. The number of sessions the injured worker has previously undergone was not provided for clinical review. The request submitted failed to provide the number of sessions requested by the physician. A treatment site was not provided for clinical review. Therefore, the request is not medically necessary.