

<b>Case Number:</b>	CM14-0097335		
<b>Date Assigned:</b>	07/28/2014	<b>Date of Injury:</b>	06/11/2012
<b>Decision Date:</b>	10/22/2014	<b>UR Denial Date:</b>	06/16/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/25/2014

### 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 Physical Medicine & Rehabilitation and is licensed to practice in Illinois. 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 32-year-old male who reported an injury on 06/11/2012 due to lifting and carrying heavy objects. The injured worker was diagnosed with inguinal sprain/strain. The past treatment included medications, hot/cold pack, physical therapy, and, chiropractic treatment. Diagnostic testing included an MRI of the lumbar spine and MRI of the groin on 08/14/20012, EMG/NCS on 09/06/2012, and MRI of the lumbar spine 05/06/2013. The injured worker underwent lumbar epidurogram to L-S1. The primary treating physician's supplemental report and review of records dated 12/05/2013 noted the injured worker presented on 07/18/2013 with complaints of low back pain with radicular leg pain, radiating to his bilateral hips, right groin, and into the thigh on. The physical examination revealed findings of lumbar disc degeneration and desiccation at L5-S1, and lumbar intervertebral disc herniation with annular tear, right L5 radiculopathy confirmed with electro diagnostic testing. The medications included Norco. The treatment plan is for topical/transdermal cream 120/150/180 gram, DOS 03/19/13 and Hydrocodone/Acetaminophen 10/325mg, qty. 120 DOS 03/19/13. The rationale for the request was not provided. The request for authorization was not submitted.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Topical/Transdermal Cream 120/150/180 gram:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

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

**Decision rationale:** The request for Topical/Transdermal Cream 120/150/180 gram, DOS 03/19/13 is not medically necessary. The injured worker complained of low back pain with radicular leg pain, radiating to his bilateral hips, right groin, and into the thigh on 07/18/2013. The California MTUS Guidelines state that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy and safety. The guidelines note topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is a lack of documentation indicating the injured worker has failed trials of antidepressants and anticonvulsants. The submitted request does not specify the ingredients of the cream being requested. Additionally, the request does not indicate the frequency at which the medication is prescribed and the site at which it is to be applied in order to determine the necessity of the medication. Given the above, the request for Topical/Transdermal Cream 120/150/180 gram, DOS 03/19/13 is not medically necessary.

**Hydrocodone Acetaminophen 10/325mg, qty 120:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78-80, 91, 124.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, and Criteria for Use Page(s): 78.

**Decision rationale:** The request for Retrospective Norco 10-325mg QID #120 DOS 03/19/13 is not medically necessary. The injured worker complained of low back pain with radicular leg pain, radiating to his bilateral hips, right groin, and into the thigh on 07/18/2013. The California MTUS guidelines recommend ongoing review with documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include current pain, the least reported pain over the period since last assessment, average pain, and intensity of pain after taking the opioid, how long it takes for pain relief, and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. The guidelines also recommend providers assess for side effects and the occurrence of any potentially aberrant (or non-adherent) drug-related behaviors. There is a lack of documentation indicating the injured worker has improved function and pain with the use of the medication. There is a lack of documentation of a measured assessment of the injured worker's pain level. There is a lack of documentation indicating urine drug screening has been performed. Additionally, the request does not indicate the frequency at which the medication is prescribed in order to determine the necessity of the medication. Therefore, the request for retrospective Norco 10/325mg QID #120 DOS 03/19/2013 is not medically necessary.