

<b>Case Number:</b>	CM14-0217590		
<b>Date Assigned:</b>	01/07/2015	<b>Date of Injury:</b>	01/30/2003
<b>Decision Date:</b>	05/14/2015	<b>UR Denial Date:</b>	12/08/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/29/2014

### 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. 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, Washington

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

### 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 62-year-old female who reported an injury on 08/07/2003. The mechanism of injury was not specifically stated. The current diagnoses include lumbar discopathy with disc displacement, status post lumbar fusion, lumbar radiculopathy and bilateral sacroiliac arthropathy. The injured worker presented on 02/23/2015 for a follow-up evaluation with complaints of residual low back pain. The injured worker also reported bilateral sacroiliac joint pain and radiating symptoms into the bilateral lower extremities. The injured worker noted an improvement in symptoms with the use of Ultram ER, Norco and a topical cream. Upon examination of the lumbar spine there was a well healed incision, tenderness to palpation over the bilateral sacroiliac joints, positive faber test, positive straight leg raise bilaterally at 20 degrees in the supine position and decreased range of motion of the lumbar spine. Motor strength was 5/5 in the bilateral lower extremities and sensation was diminished to light touch and pinprick in the bilateral S1 dermatomal distribution. Recommendations at that time included continuation of the current medication regimen, as well as a request for a TENS unit with supplies for 6 months and physical therapy for 24 sessions to include aquatic therapy. A CT scan of the lumbar spine had been approved and would be scheduled in order to determine the degree of the prior fusion and the status of hardware. A urine toxicology test was also ordered on that date. There was no Request for Authorization form submitted for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Norco 10/325 mg QTY: 140.00:** Upheld

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

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

**Decision rationale:** California MTUS Guidelines state a therapeutic trial of opioids should not be employed until a patient has failed a trial of nonopioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects should occur. In this case, there was no documentation of a failure of nonopioid analgesics. There is no evidence of objective functional improvement despite the ongoing use of this medication. There is also no frequency listed in the request. As such, the request is not medically necessary.

**Flurbiprofen 25%/Menthol 10%/Camphor 3%/Capsaicin 0.0375% 120 gm:** Upheld

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

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

**Decision rationale:** The California MTUS Guidelines state any compounded product that contains at least one drug that is not recommended, is not recommended as a whole. The only FDA approved topical NSAID is diclofenac. The request for a compounded cream containing Flurbiprofen would not be supported. Capsaicin is recommended only as an option in patients who have not responded or are intolerant to other treatments. There have been no studies of a 0.0375% formulation. There is also no frequency listed in the request. Given the above, the request is not medically necessary.

**CT scan of 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): 303-305.

**Decision rationale:** California MTUS/ACOEM Practice Guidelines state if physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss with a consultant the selection of an imaging test to define a potential cause. In this case, it was noted that the injured worker had received an approval for a CT scan of the lumbar spine to evaluate hardware and a

prior fusion. The medical necessity for an additional CT scan has not been established in this case. Therefore, the request is not medically necessary.

**Urine toxicology testing:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Urine Drug Testing Page(s): 43.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter, Urine Drug Testing.

**Decision rationale:** California MTUS Guidelines state drug testing is recommended as an option, using a urine drug screen to assess for the use or presence of illegal drugs. The Official Disability Guidelines state the frequency of urine drug testing should be based on documented evidence of risk stratification. Patients at low risk of addiction or aberrant behaviors should be tested within 6 months of initiation of therapy and on a yearly basis thereafter. As per the clinical notes submitted, there is no mention of non-compliance or misuse of medication. There is no indication that this injured worker falls under a high risk category that would require frequent monitoring. Therefore, the current request is not medically necessary.

**TENS unit with supplies times 6 months:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy, Criteria for the use of TENS Page(s): 114-121.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-117.

**Decision rationale:** California MTUS Guidelines state transcutaneous electrotherapy is not recommended as a primary treatment modality, but a 1 month home based trial may be considered as a noninvasive conservative option. In this case, it is noted that a request for a TENS unit with supplies for 6 months was also submitted in 08/2014 and 09/2014. There is no documentation of a successful 1 month trial with the TENS unit. The medical necessity for an additional request has not been established in this case. As such, the request is not medically necessary.

**Pillow cushion for driving:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg Chapter, Durable Medical Equipment.

**Decision rationale:** The Official Disability Guidelines state durable medical equipment is recommended if there is a medical need and if the device or system meets Medicare's definition of medical necessity. There is no indication that this injured worker requires a pillow cushion for driving. The medical rationale for the requested durable medical equipment was not provided. It is unclear how the durable medical equipment will improve the injured worker's current function. The medical necessity has not been established. As such, the request is not medically necessary.