

<b>Case Number:</b>	CM15-0112281		
<b>Date Assigned:</b>	06/18/2015	<b>Date of Injury:</b>	07/11/2000
<b>Decision Date:</b>	09/23/2015	<b>UR Denial Date:</b>	05/29/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/10/2015

### 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

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 54-year-old female who sustained an industrial injury on 07/11/00. Initial complaints and diagnoses are not available. Treatments to date include medications and epidural steroid injections. Diagnostic studies are not addressed. Current complaints include low back pain. Current diagnoses include lumbar degenerative disc disease, sciatica, and lumbar facet arthropathy. In a progress note dated 05/20/15 the treating provider reports the plan of care as medications including Lidoderm patches, zolpidem, cyclobenzaprine, Opana, and hydrocodone. The requested treatments include Lidoderm patches, zolpidem, cyclobenzaprine, and hydrocodone/acetaminophen.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Lidoderm 5% patches #60 with 5 refills: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm (lidocaine patch) Page(s): 57.

**Decision rationale:** The patient was injured on 07/11/00 and presents with low back pain which radiates down both legs. The request is for Lidoderm 5% patches #60 with 5 refills. The RFA is dated 05/20/15 and the patient works part time. The patient has been using these patches as early as 08/01/14. MTUS Guidelines, Lidoderm (lidocaine patch), page 57 states, "Topical lidocaine may be recommended for a localized peripheral pain after there has been evidence of a trial of first-line therapy (tricyclic or SNRI antidepressants, or an AED such as gabapentin or Lyrica)." MTUS Guidelines, under Lidocaine, page 112 also states, "Lidocaine indication: Neuropathic pain, recommended for localized peripheral pain." ODG Guidelines, Pain (Chronic) Chapter, under Lidoderm (Lidocaine Patch) specifies that the Lidoderm patches are indicated as a trial if there is "evidence of localized pain that is consistent with a neuropathic etiology." ODG further requires documentation of the area for treatment, trial of a short-term use with outcome, documenting pain and function. MTUS page 60 required recording of pain and function when medications are used for chronic pain. The patient has a positive facet loading and a positive straight leg raise. She is diagnosed with lumbar degenerative disc disease, sciatica, and lumbar facet arthropathy. In this case, the patient does not have any documentation of localized neuropathic pain as required by MTUS Guidelines. Furthermore, review of the reports provided does not indicate how Lidoderm patches have impacted the patient's pain and function. The requested Lidoderm patch is not medically necessary.

**Cyclobenzaprine HCL 10mg #90 with 4 refills:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63-66.

**Decision rationale:** The patient was injured on 07/11/00 and presents with low back pain which radiates down both legs. The request is for Cyclobenzaprine HCL 10mg #90 with 4 refills. The RFA is dated 05/20/15 and the patient works part time. It is unclear when the patient began taking this medication. MTUS Guidelines, under Muscle Relaxants, pages 63-66 states: "Muscle relaxants (for pain): Recommended non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic low back pain. The most commonly prescribed antispasmodic agents are carisoprodol, cyclobenzaprine, metaxalone, and methocarbamol, but despite the popularity, skeletal muscle relaxants should not be the primary drug class of choice for musculoskeletal conditions. Cyclobenzaprine (Flexeril, Amrix, Fexmid, generic available): Recommended for a short course of therapy." The patient has a positive facet loading and a positive straight leg raise. She is diagnosed with lumbar degenerative disc disease, sciatica, and lumbar facet arthropathy. MTUS Guidelines do not recommend the use of cyclobenzaprine for longer than 2 to 3 weeks. In this case, the request is for 90 tablets with 4 refills which exceeds the 2 to 3 weeks recommended by MTUS Guidelines. The requested Cyclobenzaprine is not medically necessary.

**Hydrocodone/Acetaminophen 10/325mg #240:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medications for chronic pain, Criteria for use of Opioids Page(s): 60, 61, 76-78, 88, 89.

**Decision rationale:** The patient was injured on 07/11/00 and presents with low back pain which radiates down both legs. The request is for Hydrocodone/Acetaminophen 10/325mg #240. The RFA is dated 05/20/15 and the patient works part time. It is unclear when the patient began taking this medication. MTUS Guidelines pages 88 and 89 under Criteria for Use of Opioids (Long-Term Users of Opioids): "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 under Criteria For Use of Opioids, Therapeutic Trial of Opioids, also requires documentation of the 4A's, analgesia, ADLs, adverse side effects, and adverse behavior, as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. MTUS Guidelines, under Opioids For Chronic Pain, pages 80 and 81 state the following regarding chronic low back pain: "Appears to be efficacious but limited for short-term pain relief, and long-term efficacy is unclear (>16 weeks), but also appears limited." Long-term use of opiates may be indicated for nociceptive pain as it is "Recommended as the standard of care for treatment of moderate or severe nociceptive pain (defined as pain that is presumed to be maintained by continual injury with the most common example being pain secondary to cancer)." However, this patient does not present with pain that is "presumed to be maintained by continual injury." On 01/14/15, the patient rated her pain as a 5-6/10. "Patient has been stable on current medication regiment and has been able to maintain function especially with activities of daily living. The patient is able to function at a higher level." On 02/12/15, she rated her pain as a 5/10. On 03/26/15, she rated her pain as a 7-8/10. On 04/22/15, she rated her pain as a 5/10. On 05/12/15, she rated her pain as a 5-6/10. "We reviewed our opioid contract, which she signed." In this case, not all of the 4A's are addressed as required by MTUS Guidelines. Although there are general pain scales provided, there are no before and after medication pain scales. There are no examples of ADLs, which neither demonstrate medication efficacy nor are there any discussions provided on adverse behavior/side effects. However, the patient is working part time. No validated instruments are used either. There are no pain management issues discussed such as CURES report, pain contract, et cetera. No outcome measures are provided as required by MTUS Guidelines. There are no urine drug screens provided to see if the patient is compliant with her prescribed medications. Although the treating physician does not provide adequate documentation that is required by MTUS Guidelines for continued opiate use, the patient is working part time. Therefore, the requested Hydrocodone is medically necessary.

**Zolpidem Tartrate 10mg #30 with 4 refills:** Upheld

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

**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 and Stress Chapter, under Zolpidem (Ambien).

**Decision rationale:** The patient was injured on 07/11/00 and presents with low back pain which radiates down both legs. The request is for Zolpidem Tartrate 10mg #30 with 4 refills. The RFA is dated 05/20/15 and the patient works part time. The patient has been taking this medication as early as 08/01/14. MTUS and ACOEM Guidelines are silent with regard to his request. However, ODG Guidelines, Mental Illness and Stress Chapter, under Zolpidem (Ambien) states, "Zolpidem (Ambien, generic available, Ambien CR) is indicated for short term use of insomnia with difficulty of sleep onset (7-10 days)." Ambien CR is indicated for treatment of insomnia with difficulty of sleep onset and/or sleep maintenance. Long-term studies have found Ambien CR to be effective for up to 24 weeks in adults. The patient has a positive facet loading and a positive straight leg raise. She is diagnosed with lumbar degenerative disc disease, sciatica, and lumbar facet arthropathy. The 01/14/15 report states "Ambien continues to alleviate the insomnia secondary to pain." ODG Guidelines support the use of Zolpidem for 7 to 10 days for insomnia. In this case, the patient has been taking Ambien since 08/01/14, which exceeds the 7-10 days recommended by ODG Guidelines. The requested Ambien is not medically necessary.

**1 Lumbar epidural steroid injection: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections Page(s): 46-47.

**Decision rationale:** The patient was injured on 07/11/00 and presents with low back pain which radiates down both legs. The request is for 1 lumbar epidural steroid injection. The RFA is dated 05/20/15 and the patient works part time. The 05/12/15 report states that the patient "used to receive an epidural steroid injection which gave her excellent pain relief." It is unclear at what level this prior injection took place. MTUS Guidelines, Epidural Steroid Injections, page 46-47 has the following criteria under its chronic pain section: "radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. In the therapeutic phase, repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year." The patient has a positive facet loading and a positive straight leg raise. She is diagnosed with lumbar degenerative disc disease, sciatica, and lumbar facet arthropathy. MTUS Guidelines require "at least 50% pain relief with associated reduction of medication use for 6 to 8 weeks," for repeat blocks. In this case, there is no numerical value provided regarding how much benefit the patient had from the prior ESI. No MRI's are provided or discussed showing potential nerve root lesions. Therefore, the requested lumbar epidural steroid injection is not medically necessary.

**1 Cervical epidural steroid injection: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 174-5.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections Page(s): 46-47.

**Decision rationale:** The patient was injured on 07/11/00 and presents with low back pain which radiates down both legs. The request is for 1 cervical epidural steroid injection. The RFA is dated 05/20/15 and the patient works part time. The 05/12/15 report states that the patient "used to receive an epidural steroid injection which gave her excellent pain relief." It is unclear at what level this prior injection took place. MTUS Guidelines, Epidural Steroid Injections, page 46-47 has the following criteria under its chronic pain section: "radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. In the therapeutic phase, repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year." The patient has a positive facet loading and a positive straight leg raise. She is diagnosed with lumbar degenerative disc disease, sciatica, and lumbar facet arthropathy. MTUS Guidelines require "at least 50% pain relief with associated reduction of medication use for 6 to 8 weeks," for repeat blocks. In this case, there is no numerical value provided regarding how much benefit the patient had from the prior ESI. No MRI reports or discussions are provided showing potential nerve root lesion either. Therefore, the requested cervical spine epidural steroid injection is not medically necessary.