

<b>Case Number:</b>	CM15-0148523		
<b>Date Assigned:</b>	08/11/2015	<b>Date of Injury:</b>	01/27/2003
<b>Decision Date:</b>	10/09/2015	<b>UR Denial Date:</b>	07/29/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/30/2015

### 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 1-27-03. The mechanism of injury was unclear. She currently complains of more stress related to the determination to not provide her with some of her medications; increased low back pain as she is helping care for her mother. Physical examination reveals severe muscle spasms with associated ligamentous, articular strain in the lumbar, sacral and pelvic areas with tenderness at the iliolumbar ligaments and sacroiliac junction on the left more than the right. Diagnoses include lumbar disc displacement; sacroilitis; somatic dysfunction, lumbar, sacral and pelvic area. Treatments to date include osteopathic manipulative medicine including traction with moderate improvement; sacroiliac belt; medications; home exercise program; transcutaneous electrical nerve stimulator unit. On 7-23-15 the treating provider requested OxyContin 40 mg #90; Norco 10-325mg #180; Norco 7.5-325mg #90; trazadone 10mg #30; Lidoderm Patches #60.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Oxycontin 40mg #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Medications for chronic pain, Opioids, criteria for use, Opioids for chronic pain.

**Decision rationale:** Based on the 4/29/15 progress report provided by the treating physician, this patient presents with increased low back pain, left > right, with no radiation into the lower extremities. The treater has asked for Oxycontin 40MG #90 but the requesting progress report is not included in the provided documentation. The patient's diagnoses per request for authorization dated 7/23/15 are LDD and failed back. The patient is experiencing stress due to the determination that she is denies lactulose, which she states is helping relieve constipation from opioid medications per 4/29/15 report. The patient is s/p lumbar traction with good results, and was given an SI belt to help support the sacroiliac joint in her daily activities per 4/29/15 report. The patient is experiencing an exacerbation of low back pain with spasms, left > right on 3/24/15 report. The patient states that despite this worsening acute pain, she doesn't have any lower extremity paresthesias, dysesthesias, or weakness per 4/29/15 report. The patient's work status is disabled per 4/29/15 report. MTUS, criteria for use of opioids Section, pages 88 and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS, criteria for use of opioids Section, page 78 also requires documentation of the 4As (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, criteria for use of opioids Section, p77, states that "function should include social, physical, psychological, daily and work activities, and should be performed using a validated instrument or numerical rating scale." MTUS, MEDICATIONS FOR CHRONIC PAIN Section, page 60 states that "Relief of pain with the use of medications is generally temporary, and measures of the lasting benefit from this modality should include evaluating the effect of pain relief in relationship to improvements in function and increased activity." The treater does not discuss this request in the reports provided. Patient has been taking Oxycontin since 12/18/13 report, and it is mentioned in 7/7/14 report and 3/10/14 report. Utilization review letter dated 7/29/15 denies request, citing a previous utilization review dated 3/30/15 recommended weaning of the same dosage of Oxycontin. MTUS requires appropriate discussion of all the 4A's; however, in addressing the 4A's, the treater does not discuss how this medication significantly improves patient's activities of daily living. No validated instrument is used to show analgesia. There is no UDS, no CURES and no opioid contract provided. Given the lack of documentation as required by MTUS, the request does not meet the specifications given by the guidelines. Therefore, the request IS NOT medically necessary.

**Norco 10/325mg #180:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Opioids, specific drug list.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Medications for chronic pain, Opioids, criteria for use, Opioids for chronic pain.

**Decision rationale:** Based on the 4/29/15 progress report provided by the treating physician, this patient presents with increased low back pain, left > right, with no radiation into the lower extremities. The treater has asked for NORCO 10/325MG #180 but the requesting progress report is not included in the provided documentation. The patient's diagnoses per request for authorization dated 7/23/15 are LDD and failed back. The patient is experiencing stress due to the determination that she is denies lactulose, which she states is helping relieve constipation from opioid medications per 4/29/15 report. The patient is s/p lumbar traction with good results, and was given an SI belt to help support the sacroiliac joint in her daily activities per 4/29/15 report. The patient is experiencing an exacerbation of low back pain with spasms, left > right on 3/24/15 report. The patient states that despite this worsening acute pain, she does not have any lower extremity paresthesias, dysesthesias, or weakness per 4/29/15 report. The patient's work status is disabled per 4/29/15 report. MTUS, CRITERIA FOR USE OF OPIOIDS Section, pages 88 and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS, CRITERIA FOR USE OF OPIOIDS Section, page 78 also requires documentation of the 4As (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, CRITERIA FOR USE OF OPIOIDS Section, p77, states that "function should include social, physical, psychological, daily and work activities, and should be performed using a validated instrument or numerical rating scale." MTUS, MEDICATIONS FOR CHRONIC PAIN Section, page 60 states that "Relief of pain with the use of medications is generally temporary, and measures of the lasting benefit from this modality should include evaluating the effect of pain relief in relationship to improvements in function and increased activity." The treater does not discuss this request in the reports provided. Patient has been taking Norco since 12/18/13 report. Utilization review letter dated 7/29/15 denies request, citing a previous utilization review dated 3/30/15 recommended weaning of the same dosage of Norco. MTUS requires appropriate discussion of all the 4A's; however, other than a general statement that "opioid use" ameliorates her pain," the treater does not discuss how this medication significantly improves patient's activities of daily living. No validated instrument is used to show analgesia. There is no UDS, no CURES and no opioid contract provided. Given the lack of documentation as required by MTUS, the request does not meet the specifications given by the guidelines. Therefore, the request IS NOT medically necessary.

**Norco 7.5/325mg #90:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Opioids, specific drug list.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Medications for chronic pain, Opioids, criteria for use, Opioids for chronic pain.

**Decision rationale:** Based on the 4/29/15 progress report provided by the treating physician, this patient presents with increased low back pain, left > right, with no radiation into the lower extremities. The treater has asked for NORCO 7.5/325MG #90 but the requesting progress report is not included in the provided documentation. The patient's diagnoses per request for authorization dated 7/23/15 are LDD and failed back. The patient is experiencing stress due to the determination that she is denies lactulose, which she states is helping relieve constipation

from opioid medications per 4/29/15 report. The patient is s/p lumbar traction with good results, and was given an SI belt to help support the sacroiliac joint in her daily activities per 4/29/15 report. The patient is experiencing an exacerbation of low back pain with spasms, left > right on 3/24/15 report. The patient states that despite this worsening acute pain, she doesn't have any lower extremity paresthesias, dysesthesias, or weakness per 4/29/15 report. The patient's work status is disabled per 4/29/15 report. MTUS, CRITERIA FOR USE OF OPIOIDS Section, pages 88 and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS, CRITERIA FOR USE OF OPIOIDS Section, page 78 also requires documentation of the 4As (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, CRITERIA FOR USE OF OPIOIDS Section, p77, states that "function should include social, physical, psychological, daily and work activities, and should be performed using a validated instrument or numerical rating scale." MTUS, MEDICATIONS FOR CHRONIC PAIN Section, page 60 states that "Relief of pain with the use of medications is generally temporary, and measures of the lasting benefit from this modality should include evaluating the effect of pain relief in relationship to improvements in function and increased activity." The treater does not discuss this request in the reports provided. Patient has been taking Norco since 12/18/13 report. The utilization review letter dated 7/29/15 denies request, citing a previous utilization review dated 3/30/15 recommended weaning of the same dosage of Norco. MTUS requires appropriate discussion of all the 4A's; however, other than a general statement that "opioid use" ameliorates her pain, the treater does not discuss how this medication significantly improves patient's activities of daily living. No validated instrument is used to show analgesia. There is no UDS, no CURES and no opioid contract provided. Given the lack of documentation as required by MTUS, the request does not meet the specifications given by the guidelines. Therefore, the request IS NOT medically necessary.

**Trazodone 10mg #30: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Mental Illness & Stress Chapter, Trazodone (Desyrel); Pain Chapter, Insomnia Treatment.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antidepressants for chronic pain. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, under Insomnia.

**Decision rationale:** Based on the 4/29/15 progress report provided by the treating physician, this patient presents with increased low back pain, left > right, with no radiation into the lower extremities. The treater has asked for TRAZODONE 10MG #30 but the requesting progress report is not included in the provided documentation. The patient's diagnoses per request for authorization dated 7/23/15 are LDD and failed back. The patient is experiencing stress due to the determination that she is denies lactulose, which she states is helping relieve constipation from opioid medications per 4/29/15 report. The patient is s/p lumbar traction with good results, and was given an SI belt to help support the sacroiliac joint in her daily activities per 4/29/15 report. The patient is experiencing an exacerbation of low back pain with spasms, left > right on 3/24/15 report. The patient states that despite this worsening acute pain, she doesn't have any lower extremity paresthesias, dysesthesias, or weakness per 4/29/15 report. The patient's work status is disabled per 4/29/15 report. MTUS Guidelines, Antidepressants for chronic pain section, pages 13-15: Recommended as a first line option for neuropathic pain,

and as a possibility for non-neuropathic pain. Tricyclics are generally considered a first-line agent unless they are ineffective, poorly tolerated, or contraindicated. Analgesia generally occurs within a few days to a week, whereas antidepressant effect takes longer to occur. ODG guidelines Pain Chapter, under Insomnia: Sedating antidepressants (e.g., amitriptyline, trazodone, mirtazapine) have also been used to treat insomnia; however, there is less evidence to support their use for insomnia, but they may be an option in patients with coexisting depression. In regard to the continuation of Trazadone, the request is not appropriate. This patient has been prescribed Trazodone at least since 7/17/14 report. Review of reports dated 7/17/15 to 4/29/15 does not mention the efficacy of Trazadone. This patient presents with chronic lower back pain. Given the lack of a discussion concerning this request, the request for continuation of Trazadone IS NOT medically necessary.

**Lidoderm Patches #60: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Lidoderm (lidocaine patch), Topical Analgesics. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic) chapter, under Lidoderm (Lidocaine patch).

**Decision rationale:** Based on the 4/29/15 progress report provided by the treating physician, this patient presents with increased low back pain, left > right, with no radiation into the lower extremities. The treater has asked for LIDODERM PATCHES #60 but the requesting progress report is not included in the provided documentation. The patient's diagnoses per request for authorization dated 7/23/15 are LDD and failed back. The patient is experiencing stress due to the determination that she is denied lactulose, which she states is helping relieve constipation from opioid medications per 4/29/15 report. The patient is s/p lumbar traction with good results, and was given an SI belt to help support the sacroiliac joint in her daily activities per 4/29/15 report. The patient is experiencing an exacerbation of low back pain with spasms, left > right on 3/24/15 report. The patient states that despite this worsening acute pain, she doesn't have any lower extremity paresthesias, dysesthesias, or weakness per 4/29/15 report. The patient's work status is disabled per 4/29/15 report. MTUS Guidelines pages 56 and 57, Lidoderm (Lidocaine patch) section states, "topical lidocaine may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). MTUS Page 112, for Topical Analgesics, also states, "Lidocaine Indication: Neuropathic pain Recommended for localized peripheral pain." When reading ODG guidelines, chapter 'Pain (Chronic)' and topic 'Lidoderm (Lidocaine patch)', it specifies that 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. The treater does not discuss this request in the reports provided. The patient has had prior use of Lidoderm patches at least since 7/17/14 report, which also states that it helps with back pain. In this case, the patient has chronic low back pain for which Lidoderm patches are not indicated. MTUS guidelines state that Lidocaine patches are appropriate for localized peripheral neuropathic pain, which this patient does not present with. This request does not meet guideline indications. Therefore, the request IS NOT medically necessary.