

<b>Case Number:</b>	CM15-0064637		
<b>Date Assigned:</b>	04/13/2015	<b>Date of Injury:</b>	04/05/2005
<b>Decision Date:</b>	06/09/2015	<b>UR Denial Date:</b>	03/23/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/07/2015

### 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: Preventive Medicine, Occupational Medicine, Public Health & General Preventive Medicine

### 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 (IW) is a 53-year-old female who sustained an industrial injury on 04/05/2005. The mechanism of injury was not provided. She reported persistent right low back pain. The injured worker was diagnosed as having lumbosacral spondylosis without myelopathy, disorders of the sacrum, and lumbago. Treatment to date has included bilateral diagnostic L3, L4, and L4 lumbar medial branch blocks with fluoroscopic guidance and contrast enhancement, sacroiliac joint injection, and medications. Currently, per the documentation of 04/05/2015, the injured worker complained of persistent left-sided axial low back pain, chronic low back pain, lumbosacral spondylosis without myelopathy sacroiliac disorder, and lumbar facet joint pain. The injured worker underwent a left sacroiliac joint injection without improvement and the medications were noted to help reduce symptoms by about 10%. Treatment plans include walking and home exercise, sleep hygiene, use of behavioral psychotherapy referral, medications of lidocaine patches, Celebrex, and Tramadol were ordered, and a request for a MRI of the spine was submitted for authorization.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Celebrex 200mg #60 with 2 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 67-68.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 67.

**Decision rationale:** The California MTUS Guidelines indicate that NSAIDS are recommended for short-term symptomatic relief of mild to moderate pain. There should be documentation of objective functional improvement and an objective decrease in pain. The clinical documentation submitted for review indicated the injured worker was utilizing the medication and it decreased the pain by 10%. There was a lack of documentation of objective functional improvement. There was a lack of documented rationale for 2 refills without re-evaluation. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Celebrex 200 mg #60 with 2 refills is not medically necessary.

**Tramadol 50mg #90 with 2 refills:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic pain, ongoing management Page(s): 60, 78.

**Decision rationale:** The clinical documentation submitted for review failed to provide documentation of objective functional improvement. The documentation indicated the injured worker's pain was decreased by 10%, which would not support the necessity for 2 refills without re-evaluation. The request as submitted failed to indicate the frequency for the requested medication. There was a lack of documentation indicating the injured worker was being monitored for aberrant drug behavior. Given the above, the request for tramadol 50 mg #90 with 2 refills is not medically necessary.

**Lidocaine 5% 700mg/patch #60 with 2 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm Page(s): 56, 57.

**Decision rationale:** The California Medical Treatment and Utilization Schedule Guidelines indicate that topical lidocaine (Lidoderm) may be recommended for 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). This is not a first line treatment and is only FDA approved for postherpetic neuralgia. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than postherpetic neuralgia. No other commercially

approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. The clinical documentation submitted for review failed to provide documentation of exceptional factors to warrant non-adherence to guideline recommendations. There was a lack of documentation of objective functional improvement with the use of the medication. The request as submitted failed to indicate the frequency for the requested medication. There was a lack of documented rationale for 2 refills without re-evaluation. Given the above, the request for lidocaine 5% 700 mg/patch is not medically necessary.

**MRI of the lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

**Decision rationale:** The physical examination failed to provide documentation of a failure of conservative care. The specific conservative care was not provided. There was a lack of documentation of unequivocal objective findings to support the need for an MRI of the lumbar spine. Given the above, the request for an MRI of the lumbar spine is not medically necessary.