

<b>Case Number:</b>	CM14-0140578		
<b>Date Assigned:</b>	09/10/2014	<b>Date of Injury:</b>	06/30/2003
<b>Decision Date:</b>	10/06/2014	<b>UR Denial Date:</b>	08/19/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/29/2014

### 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. The expert reviewer is Board Certified in Physical Medicine & Rehabilitation and is licensed to practice in California. 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:

According to the records made available for review, this is a 41-year-old male with a 6/30/03 date of injury, and status post lumbar fusion in 2005. At the time (7/31/14) of request for authorization for Methadone HCl 10mg #120, Norco 10/325 mg #120, Androgel 1.62 % 4 pumps daily, Cymbalta 60mg #60, and Left S1 Lumbar Epidural Steroid Injection, there is documentation of subjective (pain moderate to severe depending on activities, ongoing lower back pain crossing his lower back and to the left leg associated with numbness and weakness) and objective (slowed gait, two point discrimination absent over left foot, normal reflexes of upper and lower extremities, straight leg raise positive on left and negative on right, and diminished sensation along left lateral foot) findings, current diagnoses (thoracic or lumbosacral neuritis or radiculitis not otherwise specified, lumbosacral spondylosis, and testicular hypofunction not elsewhere classified), and treatment to date (previous left L5-S1 epidural steroid injection (on 3/5/14 with noted improvement including a decrease in left leg and back pain and better functionality), medications (including ongoing treatment with Methadone, Norco, Androgel, and Cymbalta with adequate pain control and ability to function and perform household and hygienic activities of daily living with medications), TENS unit, activity modifications, physical therapy, and acupuncture). Medical report identifies patient is suffering from opioid induced hypogonadism and his latest lab work showed his free testosterone level was 3.7. In addition, medical report indicates there is a signed opioid agreement on file. Regarding Methadone HCl 10mg #120, there is no documentation of Methadone used as a second-line drug, the potential benefit outweighs the risk, and that Methadone is being prescribed by providers with experience in using it. Regarding Cymbalta 60mg #60, there is no documentation of depression, generalized anxiety disorder, or pain related to diabetic

neuropathy. Regarding Left S1 Lumbar Epidural Steroid Injection, there is no documentation of at least 50-70% pain relief for six to eight weeks and decreased need for pain medications.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Methadone HCl 10mg #120: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Methadone; Opioids Page(s): 61-62; 74-80. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

**Decision rationale:** MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of Methadone used as a second-line drug for moderate to severe pain if the potential benefit outweighs the risk, and that Methadone is being prescribed by providers with experience in using it, as criteria necessary to support the medical necessity of Methadone. In addition, MTUS Chronic Pain Medical Treatment Guidelines necessitate documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects, as criteria necessary to support the medical necessity of opioids. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of thoracic or lumbosacral neuritis or radiculitis not otherwise specified, lumbosacral spondylosis, and testicular hypofunction not elsewhere classified. In addition, there is documentation of moderate to severe pain. Furthermore, given documentation of a signed opioid agreement, there is documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Moreover, given documentation of adequate pain control and ability to function and perform household and hygienic activities of daily living with medications and ongoing treatment with Methadone, there is documentation of functional benefit and improvement as an increase in activity tolerance as a result of Methadone use to date. However, there is no documentation of Methadone used as a second-line drug, the potential benefit outweighs the risk, and that Methadone is being prescribed by providers with experience in using it. Therefore, based on guidelines and a review of the evidence, the request for Methadone HCl 10mg #120 is not medically necessary.

#### **Norco 10/325 mg #120: Overturned**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-80. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

**Decision rationale:** MTUS Chronic Pain Medical Treatment Guidelines necessitate documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects, as criteria necessary to support the medical necessity of opioids. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of thoracic or lumbosacral neuritis or radiculitis not otherwise specified, lumbosacral spondylosis, and testicular hypofunction not elsewhere classified. In addition, given documentation of a signed opioid agreement, there is documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Furthermore, given documentation of adequate pain control and ability to function and perform household and hygienic activities of daily living with medications and ongoing treatment with Norco, there is documentation of functional benefit and improvement as an increase in activity tolerance as a result of Norco use to date. Therefore, based on guidelines and a review of the evidence, the request for Norco 10/325 mg #120 is medically necessary.

**Androgl 1.62 % 4 pumps daily:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Testosterone replacement for hypogonadims (related to opioids) Page(s): 110-111. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

**Decision rationale:** MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of high-dose long-term opioids and low testosterone levels, as criteria necessary to support the medical necessity of testosterone replacement therapy. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of thoracic or lumbosacral neuritis or radiculitis not otherwise specified, lumbosacral spondylosis, and testicular hypofunction not elsewhere classified. In addition, given documentation of patient is suffering from opioid

induced hypogonadism and his latest lab work showed his free testosterone level was 3.7, there is documentation of high-dose long-term opioids and low testosterone levels. Therefore, based on guidelines and a review of the evidence, the request for Androgel 1.62 % 4 Pumps daily is medically necessary.

**Cymbalta 60mg #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Duloxetine (Cymbalta) Page(s): 43-44. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter, Antidepressants for chronic pain Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

**Decision rationale:** MTUS Chronic Pain Medical Treatment Guidelines state Cymbalta is a norepinephrine and serotonin reuptake inhibitor antidepressant (SNRIs). In addition, MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of depression, generalized anxiety disorder, or pain related to diabetic neuropathy, as criteria necessary to support the medical necessity of Cymbalta. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of thoracic or lumbosacral neuritis or radiculitis not otherwise specified, lumbosacral spondylosis, and testicular hypofunction not elsewhere classified. In addition, given documentation of adequate pain control and ability to function and perform household and hygienic activities of daily living with medications and ongoing treatment with Cymbalta, there is documentation of functional benefit and improvement as an increase in activity tolerance as a result of Cymbalta use to date. However, there is no documentation of depression, generalized anxiety disorder, or pain related to diabetic neuropathy. Therefore, based on guidelines and a review of the evidence, the request for Cymbalta 60mg #60 is not medically necessary.

**Left S1 Lumbar Epidural Steroid Injection:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Epidural Steroid Injections (ESIs) Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

**Decision rationale:** MTUS reference to ACOEM guidelines identifies documentations of objective radiculopathy in an effort to avoid surgery as criteria necessary to support the medical necessity of epidural steroid injections. MTUS-Definitions identifies that any treatment

intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. ODG identifies documentation of at least 50-70% pain relief for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year, as well as decreased need for pain medications, and functional response as criteria necessary to support the medical necessity of additional epidural steroid injections. Within the medical information available for review, there is documentation of diagnoses of thoracic or lumbosacral neuritis or radiculitis not otherwise specified, lumbosacral spondylosis, and testicular hypofunction not elsewhere classified. In addition, there is documentation of a previous L5-S1 lumbar epidural steroid injection on 3/5/14. Furthermore, given documentation of noted improvement including a decrease in left leg and back pain and better functionality, there is documentation of functional response. However, there is no documentation of at least 50-70% pain relief for six to eight weeks and decreased need for pain medications. Therefore, based on guidelines and a review of the evidence, the request for Left S1 Lumbar Epidural Steroid Injection is not medically necessary.