

<b>Case Number:</b>	CM14-0148912		
<b>Date Assigned:</b>	09/18/2014	<b>Date of Injury:</b>	02/16/2010
<b>Decision Date:</b>	10/21/2014	<b>UR Denial Date:</b>	08/12/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/12/2014

### 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, has a subspecialty in Pain Management 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:

The injured worker is a 45-year-old male with a reported injury on 02/16/2010. The mechanism of injury was not provided. The injured worker's diagnoses included spasm, degeneration of lumbosacral intervertebral disc, and displacement of lumbar intervertebral disc without myelopathy. The injured worker's past treatments included medication and home exercise program. On the clinical note dated 09/05/2014, the injured worker complained of chronic pain radiating at the right and left L4-5 distribution rated 9/10. The injured worker had positive straight leg raise on both sides and tenderness noted over midline of the lumbar spine on both sides. The injured worker's medications included naproxen 550 mg twice a day, Norco 10/325 mg 3 times a day, Effexor XR 37.5 mg daily, Flector 1.3% Transdermal 12 hour patch twice daily, Fluoxetine 20 mg daily, Senna 8.6 mg 2 capsules daily, and Tizanidine 4 mg twice daily. The request was for Hydrocodone/APAP 10/325 mg #90 and Fluoxetine 20 mg #30. The rationale for the request was for pain. The request for authorization was submitted on 09/09/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Hydrocodone/APAP 10/325mg #90:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines OPIOID MANAGEMENT Page(s): 78.

**Decision rationale:** The request for Hydrocodone/APAP 10/325 mg #90 is not medically necessary. The injured worker is diagnosed with spasm, degeneration of lumbosacral intervertebral disc, and displacement of lumbar intervertebral disc without myelopathy. The injured worker complains of chronic pain with radiation at the right and left L4-5 distribution. The California MTUS Guidelines recommend an ongoing review of medications with documentation of pain relief, functional status, appropriate medication use, and side effects. The guidelines recommend that opioids for chronic back pain be limited for short term pain relief not greater than 16 weeks. There is a lack of documentation indicating the injured worker has significant objective functional improvement with medication. The requesting physician did not provide documentation of an adequate and complete assessment of the injured worker's pain. There is a lack of documentation that indicates the injured worker has decreased functional deficits. The documentation did not include a recent urine drug screen or documentation of side effects. Additionally, the request does not indicate the frequency of the medication. As such, the request for Hydrocodone/APAP 10/325 mg #90 is not medically necessary.

**Fluoxetine 20mg #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, Pain (Chronic)

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines ANTI-DEPRESSANTS Page(s): 13-16.

**Decision rationale:** The request for fluoxetine 20 mg #30 is not medically necessary. The injured worker is diagnosed with spasm, degeneration of lumbosacral intervertebral disc, and displacement of lumbar intervertebral disc without myelopathy. The injured worker complains of chronic pain with radiation at the right and left L4-5 distribution. The California MTUS Guidelines recommend antidepressants for chronic pain as a first line option for neuropathic pain and as a possibility for non-neuropathic pain. The guidelines also state antidepressants are an option, but there are no specific medications that have been proven in high quality studies to be efficacious for treatment of lumbosacral radiculopathy. There is a lack of documentation of efficacy of the medication regimen, the time frame of efficacy, the efficacy of functional status that the medication provided, and the pain rating premedication and postmedication. There is a lack of documentation that indicates the injured worker has decreased functional deficits. Additionally, the request does not indicate the frequency of the medication. As such, the request for Fluoxetine 20 mg #30 is not medically necessary.