

Case Number:	CM13-0043706		
Date Assigned:	12/27/2013	Date of Injury:	12/13/2004
Decision Date:	04/22/2014	UR Denial Date:	09/26/2013
Priority:	Standard	Application Received:	10/24/2013

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 Anesthesiology, has a subspecialty in Acupuncture & Pain Medicine 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 claimant is a 43-year-old female injured worker with date of injury 12/13/04. She has chronic lumbar backache, recurrent myofascial strain, referred pain in both lower extremities, reactive anxiety, depression and insomnia. A follow up examination documented diminished range of movements in the lumbar back and depressed mood as positive clinical findings. She has received L4-S1 transforaminal bilateral epidural injection achieving 50% to 55% sustained pain relief and improvement in functionality. MRI of the lumbar spine dated 1/25/08 revealed moderately severe disc space narrowing at the L4-L5 level with a 5mm posterior disc bulge flattening the dural sac and encroaching upon both L5 nerve roots. At the L5-S1 level, there was mild posterior disc space narrowing and a 3mm posterior disc bulge. Treatment to date has included epidural steroid injections, physical therapy, and medication management. The date of UR decision was 9/26/13.

IMR ISSUES, DECISIONS AND RATIONALES

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

A SECOND BILATERAL LUMBAR EPIDURAL STEROID INJECTION AT L4-5 AND L5-S1: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 46.

Decision rationale: Per MTUS Chronic Pain Medical Treatment Guidelines p46, Epidural steroid injection is recommended as an option for treatment of radicular pain. Current recommendations suggest a second epidural injection if partial success is produced with the first injection and a third ESI is rarely recommended. According to the MTUS Chronic Pain Medical Treatment Guidelines, the criteria for the use of Epidural steroid injections are as follows: 1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). 3) Injections should be performed using fluoroscopy (live x-ray) for guidance. 4) If used for diagnostic purposes, a maximum of two injections should be performed. A second block is not recommended if there is inadequate response to the first block. Diagnostic blocks should be at an interval of at least one to two weeks between injections. 5) No more than two nerve root levels should be injected using transforaminal blocks. 6) No more than one interlaminar level should be injected at one session. 7) 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. (Manchikanti, 2003) (CMS, 2004) (Boswell, 2007). 8) Current research does not support a "series-of-three" injections in either the diagnostic or therapeutic phase. We recommend no more than two ESI injections. The documentation submitted for review does not contain physical examination findings of radiculopathy, furthermore, an EMG/NCS of the upper and lower extremities found no evidence of cervical or lumbar radiculopathy. It is noted that a previous injection provided a maximum of 55% pain relief, but the duration of pain relief was not specified. As the criteria are not met, the request is not medically necessary.

SOMA 350MG #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

Decision rationale: Per MTUS Chronic Pain Medical Treatment Guidelines page 29, "[Carisoprodol is] Not recommended. This medication is not indicated for long-term use. Carisoprodol is a commonly prescribed, centrally acting skeletal muscle relaxant whose primary active metabolite is meprobamate (a schedule-IV controlled substance). Carisoprodol is now scheduled in several states but not on a federal level. It has been suggested that the main effect is due to generalized sedation and treatment of anxiety. Abuse has been noted for sedative and relaxant effects. In regular abusers, the main concern is the accumulation of meprobamate. Carisoprodol abuse has also been noted in order to augment or alter effects of other drugs." As this medication is not recommended by MTUS, it is found not medically necessary. It should be noted that the UR physician certified a modification of this request to accommodate weaning.

FROVA 2.5MG #9: 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) Head, Triptans.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Head, Triptans.

Decision rationale: The MTUS is silent on the use of Frova. With regard to the use of triptans, the ODG states: "Recommended for migraine sufferers. At marketed doses, all oral triptans (e.g., sumatriptan, brand name Imitrex) are effective and well tolerated. Differences among them are in general relatively small, but clinically relevant for individual patients. A poor response to one triptan does not predict a poor response to other agents in that class." The documentation submitted for review indicates that the injured worker suffered from a history of migraines. However, the most recent document mentioning complaint of migraines was dated 6/13/08. Without more current indication for this treatment, medical necessity cannot be established.

CELEBREX 100MG #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68.

Decision rationale: Regarding chronic low back pain and NSAIDs, the MTUS Chronic Pain Medical Treatment Guidelines states they are "Recommended as an option for short-term symptomatic relief. A Cochrane review of the literature on drug relief for low back pain (LBP) suggested that NSAIDs were no more effective than other drugs such as acetaminophen, narcotic analgesics, and muscle relaxants. The review also found that NSAIDs had more adverse effects than placebo and acetaminophen but fewer effects than muscle relaxants and narcotic analgesics. In addition, evidence from the review suggested that no one NSAID, including COX-2 inhibitors, was clearly more effective than another." The records submitted for review do not include evidence of acute exacerbation of pain, acute breakthrough pain, or acute pain. Without indication for this treatment, medical necessity cannot be established.

AMBIEN 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)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

Decision rationale: The MTUS is silent on the treatment of insomnia. With regard to Ambien, the ODG guidelines state "Zolpidem is a prescription short-acting nonbenzodiazepine hypnotic, which is approved for the short-term (usually two to six weeks) treatment of insomnia. Proper

sleep hygiene is critical to the individual with chronic pain and often is hard to obtain. Various medications may provide short-term benefit. While sleeping pills, so-called minor tranquilizers, and anti-anxiety agents are commonly prescribed in chronic pain, pain specialists rarely, if ever, recommend them for long-term use. They can be habit-forming, and they may impair function and memory more than opioid pain relievers may. There is also concern that they may increase pain and depression over the long-term." The documentation submitted for review indicates that the injured worker suffers from chronic insomnia. It is not indicated, however, whether she is currently suffering from an acute exacerbation of insomnia. The documentation also does not include her treatment history with Ambien, e.g. if she is currently taking it, or if it is/was effective. Without such information, medical necessity cannot be established.

PRILOSEC 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 (ODG), Pain Chapter, Proton Pump Inhibitors.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68.

Decision rationale: In the treatment of dyspepsia secondary to NSAID therapy, the MTUS recommends stopping the NSAID, switching to a different NSAID, or considering the use of an H2-receptor antagonist or a PPI. The MTUS Chronic Pain Medical Treatment Guidelines recommend the use of proton pump inhibitors in conjunction with NSAIDs in situations in which the patient is at risk for gastrointestinal events including: (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA). Chronic Pain Medical Treatment Guidelines further specify "Recommendations: Patients with no risk factor and no cardiovascular disease: Non-selective NSAIDs OK (e.g., ibuprofen, naproxen, etc.). Patients at intermediate risk for gastrointestinal events and no cardiovascular disease : (1) A non-selective NSAID with either a PPI (Proton Pump Inhibitor, for example, 20 mg omeprazole daily) or misoprostol (200 µg four times daily) or (2) a Cox-2 selective agent. Long-term PPI use (> 1 year) has been shown to increase the risk of hip fracture (adjusted odds ratio 1.44). Patients at high risk for gastrointestinal events with no cardiovascular disease: A Cox-2 selective agent plus a PPI if absolutely necessary. Patients at high risk of gastrointestinal events with cardiovascular disease: If GI risk is high the suggestion is for a low-dose Cox-2 plus low dose Aspirin (for cardioprotection) and a PPI. If cardiovascular risk is greater than GI risk, the suggestion is naproxen plus low-dose aspirin plus a PPI. (Laine, 2006) (Scholmerich, 2006) (Nielsen, 2006) (Chan, 2004) (Gold, 2007) (Laine, 2007)". Because this injured worker is negative for history of peptic ulcer, GI bleeding or perforation, and does not have cardiovascular disease, his risk for gastrointestinal events is low, as such, this request is not medically necessary. Furthermore, NSAID therapy is not recommended for this patient.

TEROCIN PAIN LOTION: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 105-111-113.

Decision rationale: Terocin is capsaicin, lidocaine, menthol, methyl salicylate, and boswellia serrata. Capsaicin may have an indication for chronic lower back pain in this context. Per MTUS p 112 "Indications: There are positive randomized studies with capsaicin cream in patients with osteoarthritis, fibromyalgia, and chronic non-specific back pain, but it should be considered experimental in very high doses. Although topical capsaicin has moderate to poor efficacy, it may be particularly useful (alone or in conjunction with other modalities) in patients whose pain has not been controlled successfully with conventional therapy." Methyl salicylate may have an indication for chronic pain in this context. Per MTUS p105, "Recommended. Topical salicylate (e.g., Ben-Gay, methyl salicylate) is significantly better than placebo in chronic pain. (Mason-BMJ, 2004)." However, the other ingredients in Terocin are not indicated. The preponderance of evidence indicates that overall, this medication is not medically necessary. Regarding topical lidocaine, MTUS states (p112) "Non-neuropathic pain: Not recommended. There is only one trial that tested 4% lidocaine for treatment of chronic muscle pain. The results showed there was no superiority over placebo. (Scudds, 1995)." Per MTUS p25 Boswellia Serrata Resin is not recommended for chronic pain. Terocin topical lotion contains menthol. The CA MTUS, ODG, National Guidelines Clearinghouse, and ACOEM provide no evidence-based recommendations regarding the topical application of menthol. It is the opinion of this IMR reviewer that a lack of endorsement, a lack of mention, inherently implies a lack of recommendation, or a status equivalent to "not recommended". Since menthol is not medically indicated, then the overall product is not indicated per MTUS as outlined below. Note the statement on page 111: Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Regarding the use of multiple medications, MTUS p60 states, "Only one medication should be given at a time, and interventions that are active and passive should remain unchanged at the time of the medication change. A trial should be given for each individual medication. Analgesic medications should show effects within 1 to 3 days, and the analgesic effect of antidepressants should occur within 1 week. A record of pain and function with the medication should be recorded. (Mens, 2005) The recent AHRQ review of comparative effectiveness and safety of analgesics for osteoarthritis concluded that each of the analgesics was associated with a unique set of benefits and risks, and no currently available analgesic was identified as offering a clear overall advantage compared with the others." Therefore, it would be optimal to trial each medication individually.

TROCHANTERIC BURSA INJECTION TO THE RIGHT HIP: 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) Hip & Pelvis, Trochanteric bursitis injections.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hip & Pelvis, Trochanteric bursitis injections.

Decision rationale: The MTUS is silent on trochanteric bursa injection. Per the ODG TWC, trochanteric bursitis injections are recommended. "Gluteus medius tendinosis/tears and

trochanteric bursitis/pain are symptoms that are often related, and commonly correspond with shoulder tendinosis and subacromial bursitis, though there is no evidence of a direct correlation between the hip and shoulder. All of these disorders are associated with hip pain and morbidity. (Cormier, 2006) (Lonner, 2002) (Bird, 2001) (Chung, 1999) (Kingzett-Taylor, 1999) (Howell, 2001) For trochanteric pain, corticosteroid injection is safe and highly effective, with a single corticosteroid injection often providing satisfactory pain relief (level of evidence, C).

Trochanteric bursitis is the second leading cause of hip pain in adults, and a steroid-anesthetic single injection can provide rapid and prolonged relief, with a 2.7-fold increase in the number of patients who were pain-free at 5 years after a single injection. Steroid injection should be offered as a first-line treatment of trochanteric bursitis, particularly in older adults. Trochanteric corticosteroid injection is a simple, safe procedure that can be diagnostic as well as therapeutic." However, the documentation submitted for review does not include any evidence of greater trochanteric bursitis on clinical examination. Without indication for this treatment, medical necessity cannot be established.

A SERIES OF TRIGGER POINT INJECTIONS: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 122.

Decision rationale: With regard to trigger point injections, the MTUS Chronic Pain Medical Treatment Guidelines state: Recommended only for myofascial pain syndrome as indicated below, with limited lasting value." "Criteria for the use of Trigger point injections: Trigger point injections with a local anesthetic may be recommended for the treatment of chronic low back or neck pain with myofascial pain syndrome when all of the following criteria are met: (1) Documentation of circumscribed trigger points with evidence upon palpation of a twitch response as well as referred pain; (2) Symptoms have persisted for more than three months; (3) Medical management therapies such as ongoing stretching exercises, physical therapy, NSAIDs and muscle relaxants have failed to control pain; (4) Radiculopathy is not present (by exam, imaging, or neuro-testing); (5) Not more than 3-4 injections per session; (6) No repeat injections unless a greater than 50% pain relief is obtained for six weeks after an injection and there is documented evidence of functional improvement; (7) Frequency should not be at an interval less than two months; (8) Trigger point injections with any substance (e.g., saline or glucose) other than local anesthetic with or without steroid are not recommended. (Colorado, 2002) (BlueCross BlueShield, 2004)". The documentation submitted for review does not include findings of trigger points, or evidence of failure of conservative treatment. The request is not medically necessary.