

Case Number:	CM13-0049255		
Date Assigned:	01/03/2014	Date of Injury:	01/22/2009
Decision Date:	04/24/2014	UR Denial Date:	10/13/2013
Priority:	Standard	Application Received:	11/07/2013

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 Internal Medicine, and is licensed to practice in Florida. 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:

This patient is a 51 year-old with a date of injury of 01/22/09. A progress report associated with the request for services, dated 10/22/13, identified subjective complaints of low back & right shoulder pain. There is no history of ischemic heart disease and no gastrointestinal complaints. Objective findings included tenderness to palpation of the lumbar spine with decreased sensation in the S1 dermatome. Motor function was normal. MRI showed lumbar disc disease. Diagnoses included lumbar disc disease with sciatica. Treatment has included a previous lumbar fusion and physical therapy. She is on oral analgesics, anticonvulsants, NSAIDs, muscle relaxants, and topical therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

RETROSPECTIVE REQUEST FOR CYCLOBENZAPRINE- FLEXERIL 7.5MG BETWEEN 08/30/13 AND 08/30/2013: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine Page(s): 41-42, 63-66.

Decision rationale: The MTUS Chronic Pain Guidelines state that non-sedating muscle relaxants are recommended with caution as a second-line option for short-term treatment of acute exacerbations of low back pain. They note that in most low-back pain cases, they show no benefit beyond NSAIDs in pain and overall improvement. Also, there is no additional benefit shown in combination of NSAIDs. Likewise, the efficacy diminishes over time. The MTUS Chronic Pain Guidelines state that Cyclobenzaprine (Flexeril) is indicated as a short course of therapy. Limited, mixed evidence does not allow a recommendation for Cyclobenzaprine for chronic use. Though it is noted that Cyclobenzaprine is more effective than placebo in the management of back pain; the effect is modest and comes at the price of greater adverse effects. They further state that treatment should be brief and that addition of Cyclobenzaprine to other agents is not recommended. The Guidelines do note that Cyclobenzaprine has been shown to produce a moderate benefit in the treatment of fibromyalgia. The record does not show any evidence of fibromyalgia, and other indications for Cyclobenzaprine beyond a short course are not well supported. Likewise, it is being used in combination with other agents; particularly NSAIDs for which no additional benefit has been shown. Therefore, in this case, the request is not medically necessary and appropriate.

RETROSPECTIVE REQUEST FOR DOXEPIN 3.3% GEL 60 GM BETWEEN 08/30/2013 AND 08/30/2013: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines.

Decision rationale: Doxepin is a tricyclic antidepressant. The MTUS Chronic Pain Guidelines state that topical analgesics are recommended as an option in specific circumstances. However, they do state that they are "Largely experimental in use with few randomized controlled trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed." Neither the MTUS nor Official Disability Guidelines address or recommend a tricyclic antidepressant topical agent. There is no peer-reviewed literature to support use. In this case, there is no documentation of functional improvement nor specific recommendation for doxepin gel. Therefore, there is no documented medical necessity for doxepin gel.

RETROSPECTIVE REQUEST FOR 60 PANTOPROZOLE-PROTONIX 20MG BETWEEN 08/30/2013 AND 08/30/2013: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines section on NSAIDs Page(s): 68-69.

Decision rationale: Protonix, a proton pump inhibitor, is a gastric antacid. It is sometimes used for prophylaxis against the GI side effects of NSAIDs based upon the patient's risk factors. The MTUS Chronic Pain Guidelines notes that these risk factors include "(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 NSAIDs." The use of non-selective NSAIDs without prophylaxis is considered "okay" in patients with no risk factors and no cardiovascular disease. In this case, the patient was prescribed ibuprofen, but there is no documentation of any of the above risk factors. Therefore, the medical record does not document the medical necessity for Protonix. The request is not medically necessary and appropriate.

RETROSPECTIVE REQUEST FOR 90 HYDROCODONE BIT/APAP 5/500 MG BETWEEN 08/30/2013 AND 08/30/2013: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308, Chronic Pain Treatment Guidelines section on Opioids Page(s): 74-83.

Decision rationale: The patient is on chronic hydrocodone with acetaminophen. This is classified as an opioid analgesic in combination with acetaminophen. The MTUS Chronic Pain Guidelines related to on-going treatment of opioids state that there should be documentation and ongoing review of pain relief, functional status, appropriate use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. The documentation provided for review lacked a number of the elements listed above, including the level of functional improvement afforded by the chronic opioid therapy. The Guidelines also state that with chronic low back pain, opioid therapy "Appears to be efficacious but limited for short-term pain relief, and long-term efficacy is unclear (> 16 weeks), but also appears limited." Additionally, "There is also no evidence that opioids showed long-term benefit or improvement in function when used as treatment for chronic back pain (Martell - Annals, 2007)." The MTUS Chronic Pain Guidelines further state that opioids are not recommended for more than 2 weeks for low back complaints. The patient has been on opioids well in excess of 16 weeks. The request is not medically necessary and appropriate.

RETROSPECTIVE REQUEST FOR 120 GABAPENTIN TABLETS 600 MG BETWEEN 08/30/2013 AND 08/30/2013: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy Drugs Page(s): 16-21, 49.

Decision rationale: Gabapentin (Neurontin) is an anti-seizure agent. The MTUS Chronic Pain Guidelines note that this class of agents is recommended for neuropathic pain, but there are few randomized trials directed at central pain and none for painful radiculopathy. Further, it states: "A recent review has indicated that there is insufficient evidence to recommend for or against antiepileptic drugs for axial low back pain." The Guidelines also state that the role for Gabapentin is for: "...treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered first-line treatment for neuropathic pain." No recommendations are made for specific musculoskeletal etiologies. In this case, there is no documentation for a neuropathic component to the pain, and little evidence to support its use in low back pain and radiculopathy. Also, there is no evidence of functional improvement from the Neurontin. Therefore, the request is not medically necessary and appropriate.