

Case Number:	CM14-0002052		
Date Assigned:	01/24/2014	Date of Injury:	05/23/2012
Decision Date:	06/12/2014	UR Denial Date:	12/30/2013
Priority:	Standard	Application Received:	01/08/2014

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 Occupational 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:

Injured worker reported a date of injury of 5/23/2012. Per primary treating physician's progress report, the injured worker complains of constant mid back pain radiating to the upper extremities, 8-9/10, and constant low back pain radiating to the lower extremities, 9-10/10. She is status post lumbar epidural 11/15/2013 #4 with no benefit. On exam cervical range of motion is flexion 40 degrees, extension 50 degrees, bilateral rotation 65 degrees, bilateral flexion 30 degrees. Lumbar range of motion is flexion 35 degrees, extension 10 degrees, bilateral flexion 15 degrees. Lumbar spine is tender. Diagnoses include 1) neck sprain/strain 2) lumbar spondylosis 3) lumbar spinal stenosis 4) lumbar radiculopathy.

IMR ISSUES, DECISIONS AND RATIONALES

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

RESTORIL 15 MG, #30: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines BENZODIAZEPINES Page(s): 24.

Decision rationale: Restoril is a benzodiazepine medication. The MTUS guidelines do not recommend the use of benzodiazepines for long-term use because long-term efficacy is unproven

and there is a risk of dependence, and long-term use may actually increase anxiety. The claims administrator approved the request for Restoril, but modified it to specify no refills. The injured worker is being prescribed 30 tablets, and there are no refills currently prescribed. It does not appear that the injured worker has been on this medication chronically based on the urine drug screen results and previous progress notes. The request for Restoril appears to be for short term use, and is therefore consistent with the MTUS. Therefore, the request for Restoril 15 mg #30 is determined to be medically necessary and appropriate.

PERCOCET 10/325 MG, #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS; WEANING OF MEDICATIONS Page(s): 74-95; 124.

Decision rationale: The claims administrator reports that the requesting provider has not addressed the result of the urine drug screening to show compliance with the medication regimen. Previous UR reports have allowed for limited use of the prescribed opioids to allow time to address this deficiency. In this review, there are inconsistencies reported in the urine drug screens, and these are not addressed by the requesting provider. The injured worker is being treated chronically with opioid pain medications and she continues to have uncontrolled pain. There is no report of increased function with the use of this medication. The guidelines do not recommend the use of opioid pain medications, in general, for the management of chronic pain. They do provide guidance on the rare instance where opioids are needed in maintenance therapy, but the emphasis should remain on non-opioid pain medications and active therapy, which is not the case in the current management of this injured worker. It is not recommended to discontinue opioid treatment abruptly, as weaning of medications is necessary to avoid withdrawal symptoms when opioids have been used chronically. This request however is not for a weaning treatment, but to maintain treatment. Therefore, the request for Percocet 10/325 mg #120 is not medically necessary and appropriate.

SOMA 350 MG, #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CARISOPRODOL (SOMA).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CARISOPRODOL (SOMA); WEANING OF MEDICATIONS Page(s): 29; 124.

Decision rationale: The guidelines do not recommend the use of Soma, and specifically state that the medication is not indicated for long-term use. There are precautions with sudden discontinuation of this medication due to withdrawal symptoms in chronic users. This medication should be tapered, or side effects of withdrawal should be managed by other means. Therefore, the request for Soma 350 mg #90 is not medically necessary and appropriate.

TEROCIN PAIN PATCH, 10 PATCHES, #3: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL CAPSAICIN; SALICYLATE TOPICALS; TOPICAL ANALGESICS Page(s): 28; 104; 111-113.

Decision rationale: Per manufacturer's information, Terocin patch is a combination topical analgesic with active ingredients that include capsaicin 0.025%, menthol 10%, lidocaine 2.5%, and methyl salicylate 25%. Topical capsaicin is recommended by the guidelines only as an option in patients who have not responded or are intolerant to other treatments. There are positive randomized studies with capsaicin cream in patients with osteoarthritis, fibromyalgia, and chronic non-specific back pain. Topical lidocaine is not recommended for non-neuropathic pain, and recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy such as tri-cyclic anti-depressant, SNRI anti-depressants or an anti-epilepsy drug such as gabapentin or Lyrica. Salicylate topicals are recommended by the guidelines, as it is significantly better than placebo in chronic pain. Menthol is not addressed by the guidelines, but it is often included in formulations of anesthetic agents. It induces tingling and cooling sensations when applied topically. Menthol induces analgesia through calcium channel-blocking actions, as well as binding to kappa-opioid receptors. Menthol is also an effective topical permeation enhancer for water-soluble drugs. There are reports of negative effects from high doses of menthol such as 40% preparations. Topical analgesics are recommended by the guidelines. Compounded topical analgesics that contain at least one drug or drug class that is not recommended is not recommended. For this request, topical lidocaine is not indicated for use with this injured worker. Topical lidocaine is used primarily for neuropathic pain when trials of antidepressant and anticonvulsants have failed. There is no clear evidence in the clinical reports that this injured worker has neuropathic pain that has failed treatment with trials of antidepressants and anticonvulsants. Therefore, the request for Terocin pain patch, 10 patches, #3 is not medically necessary and appropriate.

FLURBI 180 GM: Upheld

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

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

Decision rationale: This request is for the compounded topical analgesic containing flurbiprofen, lidocaine and amitriptyline. Topical lidocaine is not recommended for non-neuropathic pain, and recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy such as tri-cyclic anti-depressant, SNRI anti-depressants or an anti-epilepsy drug such as gabapentin or Lyrica. Topical analgesics are recommended by the guidelines. Compounded topical analgesics that contain at least one drug or drug class that is not

recommended is not recommended. For this request, topical lidocaine is not indicated for use with this injured worker. Topical lidocaine is used primarily for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is no clear evidence in the clinical reports that this injured worker has neuropathic pain that has failed treatment with trials of antidepressants and anticonvulsants. Therefore, the request for Flurbi 180 gm is not medically necessary and appropriate.

GABACYCLOTRAM 180 GM: Upheld

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

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

Decision rationale: Gabacyclotram is a compounded topical analgesic containing gabapentin, cyclobenzaprine and tramadol. Topical analgesics are recommended by the guidelines. Compounded topical analgesics that contain at least one drug or drug class that is not recommended is not recommended. The MTUS guidelines specifically do not recommend the use of topical gabapentin, stating that there is no peer-reviewed literature to support this. Therefore, the request for Gabacyclotram not medically necessary and appropriate.

GENICIN 500 MG, #90: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines GLUCOSAMINE (AND CHONDROITIN SULFATE) Page(s): 50.

Decision rationale: Genicin contains glucosamine 500 mg. The MTUS guidelines recommend the use of glucosamine in moderate arthritis, especially in knee osteoarthritis. This injured worker has back pain with the following diagnoses: 1) neck sprain/strain 2) lumbar spondylosis 3) lumbar spinal stenosis 4) lumbar radiculopathy. The use of glucosamine is not supported for these problems by the guidelines. Therefore, the request for Genicin 500 mg #90 is not medically necessary and appropriate.

SOMNICIN, #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), Medical Foods.

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

Decision rationale: Somnicin contains melatonin 2 mg, 5HTP 50 mg, L tryptophan 100mg, pyridoxine 10 mg, magnesium 50 mg. It is marketed as a natural sleep aid. Per the ODG, insomnia treatment should be based on the etiology. Pharmacological sleep aids are only recommended after careful evaluation of potential causes of sleep disturbance. Failure of sleep disturbance to resolve in a 7 to 10 day period may indicate a psychiatric and/or medical illness. The requesting provider does not provide a clear evaluation of the sleep problems, and is prescribing this sleep aid for a prolonged period, inconsistent with the recommendations of the guidelines. Therefore, the request for Somnicin #30 is not medically necessary and appropriate.

CARDIO-RESPIRATORY TESTING: 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, Autonomic Testing.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Ats.Accp Statement On Cardiopulmonary Exercise Testing, American Journal Of Respiratory And Critical Care Medicine, Vol 167; page 211-277, 2003.

Decision rationale: Per the cited reference, the indications for cardio-respiratory testing include 1) evaluation of exercise tolerance 2) evaluation of undiagnosed exercise intolerance 3) evaluation of patients with cardiovascular diseases 4) evaluation of patients with respiratory diseases/symptoms 5) preoperative evaluation 6) exercise evaluation and prescription for pulmonary rehabilitation 7) evaluation of impairment/disability 8) evaluation for lung, heart, and heart-lung transplantation. On review of the clinical, there does not appear to be any clear clinical indications for this injured worker to have cardio-respiratory testing. Therefore, the request for cardio-respiratory testing is not medically necessary and appropriate.

L5-S1 TRANSFORAMINAL ESI, #3: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines EPIDURAL STEROID INJECTIONS (ESI) Page(s): 46.

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

Decision rationale: It is noted that a previous request for transforaminal epidural steroid injection was denied because of conflicting medical reports. Following a previous epidural steroid injection, there was a report that there was a 90% response, but the injured worker's reported back pain was rated at 9/10, when it was previously reported as 8/10. The injured worker also reported that there was no change in radicular pain. There was also no documented reduction in medication usage following the epidural steroid injection. Epidural steroid injections are recommended by the guidelines when the patient's condition meets certain criteria, including radiculopathy being documented by physical exam and corroborated by imaging studies and/or

electrodiagnostic testing, and failed conservative treatment. The injured worker does meet these conditions, this is for a repeat injection. Repeat blocks should only be considered if there is objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks. The conditions for a repeat block have not been met as it is not likely that providing additional blocks will provide sufficient benefit to the injured worker. Therefore, the request for L5-S1 transforaminal ESI #3 is not medically necessary and appropriate.

AUTONOMIC FUNCTION ASSESSMENT: 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, Autonomic Testing.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Autonomic Nervous System Function Testing.

Decision rationale: The ODG does not recommend the use of autonomic nervous system function testing. This test is generally used for CRPS, which the injured worker does not have this diagnosis, or a documented clinical presentation that would suggest she has CRPS. Therefore, the request for autonomic function assessment is not medically necessary and appropriate.

CARDIOVAGAL INNERVATION: 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, Autonomic Testing.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Autonomic Nervous System Function Testing.

Decision rationale: Cardiovascular innervation is related to autonomic function assessment. The ODG does not recommend the use of autonomic nervous system function testing. This test is generally used for CRPS, which the injured worker does not have this diagnosis, or a documented clinical presentation that would suggest she has CRPS. Therefore, the request for cardiovascular innervation is not medically necessary and appropriate.

VASOMOTOR ADRENERGIC INNERVATION: 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, Autonomic Testing.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Autonomic Nervous System Function Testing.

Decision rationale: Vasomotor adrenergic innervation is related to autonomic function assessment. The ODG does not recommend the use of autonomic nervous system function testing. This test is generally used for CRPS, which the injured worker does not have this diagnosis, or a documented clinical presentation that would suggest she has CRPS. Therefore, the request for vasomotor adrenergic innervation is not medically necessary and appropriate.

ELECTROCARDIOGRAM: 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, Autonomic Testing.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Autonomic Nervous System Function Testing.

Decision rationale: The request for electrocardiogram is related to the request for autonomic function assessment. The ODG does not recommend the use of autonomic nervous system function testing. This test is generally used for CRPS, which the injured worker does not have this diagnosis, or a documented clinical presentation that would suggest she has CRPS. Therefore, the request for electrocardiogram is not medically necessary and appropriate.