

Case Number:	CM14-0014439		
Date Assigned:	02/28/2014	Date of Injury:	02/04/2008
Decision Date:	09/05/2014	UR Denial Date:	01/10/2014
Priority:	Standard	Application Received:	02/05/2014

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:

The patient is a 53-year-old female who has submitted a claim for cervical radiculopathy, lumbar radiculopathy, hypertension, chronic pain, status post left total knee arthroplasty, and history of gastric bypass associated with an industrial injury date of February 4, 2008. Medical records from 2013-2014 were reviewed. The patient complained of neck pain, rated 6-9/10. The pain radiates bilaterally in the upper extremities. The pain increases with activity and walking. Physical examination showed spinal vertebral tenderness on C5-C7. Sensory examination showed decreased sensation bilaterally. Motor strength was intact. MRI of the cervical spine, dated November 8, 2008, revealed C4-C5 central disc protrusion with ventral narrowing of the thecal sac and mild narrowing of the lateral recesses bilaterally, and C5-C6 and C6-C7 desiccation and central disc protrusion with ventral effacement of the thecal sac and contact with the ventral aspect of the spinal cord and moderate narrowing of the lateral recesses bilaterally. Treatment to date has included medications, physical therapy, acupuncture, home exercise program, activity modification, gastric bypass surgery, left total knee arthroplasty, left knee arthroscopy, and lumbar epidural steroid injection. Utilization review, dated January 10, 2014, denied the request for bilateral C4-C7 cervical epidural injections because there was no documentation of objective functional improvement or documentation of reduced medication from the previous injection and the guideline supports injection up to 2 levels only; denied Exoten-C and Voltaren gel because there was no documentation confirming that the patient failed trial of first line treatment; denied Restone because no documentation was provided confirming the patient has nutritional deficits or regarding the patient's sleep history; denied the request for Senokot because there was no information that the patient was having issues with constipation; and denied the request for Zolpidem because guidelines support short-term use of the medication. An appeal, dated January 16, 2014, stated that patient should be authorize treatment as requested because the patient had

persistent pain and failed more conservative treatment. The use of Senokot was used to reduce effect of chronic constipation associated with opioid use and conservative measures have been ineffective. Zolpidem can be prescribed for longer durations in difficult cases and has been helpful in improving sleep quality and duration.

IMR ISSUES, DECISIONS AND RATIONALES

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

BI-LATERAL C4-7 CERVICAL EPIDURAL: Upheld

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

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

Decision rationale: According to page 46 of the CA MTUS Chronic Pain Medical Treatment Guidelines, criteria for epidural steroid injections include the following: radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing; initially unresponsive to conservative treatment; and no more than two nerve root levels should be injected using transforaminal blocks. Guidelines do not support epidural injections in the absence of objective radiculopathy. In addition, repeat epidural steroid injection 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. In this case, the patient has persistent neck pain that radiates to the bilateral upper extremities. The patient only presented with decreased sensation of the upper extremities bilaterally. MRI of the cervical spine dated November 8, 2008 revealed C4-C5 ventral narrowing of the thecal sac and mild narrowing of the lateral recesses, and C5-C6 and C6-C7 ventral effacement of the thecal sac and moderate narrowing of the lateral recesses bilaterally. There is not enough evidence of radiculopathy in this case. Furthermore, there was no evidence that patient was unresponsive to conservative treatment. The guideline criteria have not been met. Therefore, the request for BI-LATERAL C4-7 CERVICAL EPIDURAL is not medically necessary.

EXOTEN-C LOTION 120 ML #240: Overturned

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

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 (ODG) Pain Section, Topical Salicylates.

Decision rationale: Pages 111-113 of the CA MTUS Chronic Pain Medical Treatment Guidelines state that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Regarding the capsaicin component, the

guideline states there is no current indication that an increase over a 0.025% formulation would provide any further efficacy. According to the guideline, topical salicylate is significantly better than placebo in chronic pain. Regarding the Menthol component, CA MTUS does not cite specific provisions, but the ODG Pain Chapter states that the FDA has issued an alert in 2012 indicating that topical OTC pain relievers that contain menthol, methyl salicylate, or capsaicin, may in rare instances cause serious burns. In this case, Exoten-C was prescribed since August 2013. It was prescribed for pain control and to reduce total oral analgesic dose requirement. It is a reasonable treatment option at this time. Therefore, the request for EXOTEN-C LOTION 120ML #240 is medically necessary.

RESTONE 3-100MG #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.drugs.com/melatonin.html>.

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, Melatonin; Pain Chapter, Medical Food.

Decision rationale: The CA MTUS does not address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, ODG was used instead. According to ODG, melatonin is recommended for insomnia treatment. Repeated administration improves sleep and may reduce anxiety. There are also data supporting an analgesic role of melatonin in a dose-dependent manner. According to ODG, 5-hydroxytryptophan is possibly effective in treatment of anxiety disorders, fibromyalgia, obesity, and sleep disorders. It has been found to be effective for depression. It should be used with caution in individuals using SSRIs. In this case, patient has been using this medication since August 2013. However, there is no documentation of the patient's sleeping habits or baseline status to support improvement derived from this medication. There is insufficient information to support the use of this medication in this patient. Therefore, the request for RESTONE 3-100MG #30 is not medically necessary.

SENOKOT 50/8.6 #60: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.drugs.com/cdl/senokot-s.html>.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines , Opioid Page(s): 77. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: FDA (Senna).

Decision rationale: As stated on page 77 of the CA MTUS Chronic Pain Medical Treatment Guidelines, prophylactic treatment of constipation should be initiated with opioid treatment. The FDA states that Senna is indicated for short-term treatment of constipation, and preoperative and pre-radiographic bowel evacuation or for procedures involving GI tract. In this case, the patient has been on this medication since August 2013 although exact date of initiation is not known.

This medication is necessary to manage constipation associated with chronic opioid therapy. However, recent progress report dated January 24, 2014 showed that there are no opioid medications being taken by the patient. Moreover, complaints of constipation were not documented from the recent clinical records submitted for review. The guideline criteria have not been met. Therefore, the request for SENOKOT-S 8.6/50MG #200 is not medically necessary.

ZOLPIDEM TARTRATE 10MG #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ODG), Stress & Mental Illness Chapter.

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, Zolpidem.

Decision rationale: CA MTUS does not specifically address this issue. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Official Disability Guidelines (ODG) was used instead. ODG, Pain chapter states that Zolpidem is a prescription short-acting non-benzodiazepine hypnotic, which is approved for the short-term (usually two to six weeks) treatment of insomnia. In this case, the patient was taking Zolpidem since August 2013 but exact date of initiation was not known. There was no mention regarding the patient's sleeping habits that warrant the use of Zolpidem. Although an appeal dated January 16, 2014 stated that the medication has been helpful in improving sleep and quality and duration, long-term use of Zolpidem is not recommended. Therefore, the request for ZOLPIDEM TARTRATE 10MG #30 is not medically necessary.

VOLTAREN 1% GEL #100: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112.

Decision rationale: According to CA MTUS Chronic Pain Treatment Guidelines, topical NSAIDs are recommended for osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment. There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. In this case, patient has been using Voltaren gel since August 2013 for the neck and low back pain. However, there was no documentation of continued functional benefit with this medication. Moreover, the use of Voltaren has little evidence of its use for the cervical or lumbar spine. Furthermore, the medical records also failed to provide evidence of osteoarthritis, which may warrant the use of Voltaren Gel. There is no clear indication for continued use of this medication. Therefore, the request for prescription of VOLTAREN 1% GEL #100 is not medically necessary.