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| Case Number: | CM14-0133456 | | |
| Date Assigned: | 08/27/2014 | Date of Injury: | 12/07/2005 |
| Decision Date: | 10/23/2014 | UR Denial Date: | 07/28/2014 |
| Priority: | Standard | Application Received: | 08/20/2014 |

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 Family Medicine and is licensed to practice in Arizona. 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:

Patient is a 45 year old female with a date of injury on 12/7/2005. Diagnoses include failed back syndrome, lumbar facet arthritis, lumbar degenerative disc disease and myofascial pain syndrome. Subjective complaints are of low back, bilateral thigh pain and right forearm pain. Pain is rated at 7/10. Records report that burning and tingling in forearm is reduced with gabapentin. It is also noted that the patient has significant improvement in function with medications. Physical exam shows diffuse tenderness over the lumbosacral region and upper buttocks and tenderness over the sacroiliac (SI) joints. Lumbar flexion is decreased, and there is a positive straight leg raise test and dysesthesia down posterior legs from sacrum across buttock to the heels. Medications include Oxycodone, Elavil, Neurontin, Pepcid, and Zanaflex.

IMR ISSUES, DECISIONS AND RATIONALES

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

Oxycodone IR 15mg, #150: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids
Page(s): 74-96.

Decision rationale: The patient in question has been on chronic opioid therapy. CA Chronic Pain Guidelines has specific recommendations for the ongoing management of opioid therapy. Clear evidence should be presented about the degree of analgesia, level of activity of daily living, adverse side effects, or aberrant drug taking behavior. For this patient, documentation shows stability on medication, increased functional ability, and no adverse side effects. Furthermore, documentation is present of MTUS opioid compliance guidelines including urine drug screen, risk assessment, and ongoing efficacy of medication. Therefore, the use of this medication is consistent with guidelines and is medically necessary for this patient.

Elavil with three refills: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for Chronic Pain, Tricyclic Antidepressants, Amitr. Decision based on Non-MTUS Citation Official Disability Guidelines, SSRIs vs. Tricyclics

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants Page(s): 14-16.

Decision rationale: CA MTUS recommends antidepressants as a first line option for neuropathic pain, and as a possibility for non-neuropathic pain. Tricyclics are considered first line unless they are ineffective, poorly tolerated, or contraindicated. This patient has documented evidence of neuropathic pain. Therefore, the use of Elavil is consistent with guideline recommendations and the medical necessity is established.

Neurontin with three refills: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy Drugs (AEDs), Gabapentin (Neurontin).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines AED Page(s): 16-22.

Decision rationale: CA MTUS indicates that gabapentin is an anti-seizure medication that is recommended for neuropathic pain. CA MTUS also adds that following initiation of treatment there should be documentation of at least 30% pain relief and functional improvement. The continued use of an AED for neuropathic pain depends on these improved outcomes. Review of the submitted medical records demonstrated neuropathic pain, and pain relief and functional improvement was documented with this medication. Therefore, the medical necessity for gabapentin is established.

Pepcid with three refills: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation www.webmd.com/drugs

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS/GI risk Page(s): 68-69.

Decision rationale: According to CA MTUS guidelines, a proton pump inhibitor or an H2 blocker can be added to non-steroidal anti-inflammatory drug (NSAID) therapy if the patient is at an intermediate to high risk for adverse gastrointestinal (GI) events. Guidelines identify the following as risk factors for GI events: age >65, history of peptic ulcer, GI bleeding or perforation, use of acetylsalicylic acid (ASA), corticosteroids, anticoagulant use, or high dose NSAIDS. For this patient, no GI risk factors were identified, and ongoing gastric complaints were not evident. Therefore, the medical necessity for Pepcid is not established at this time.

Zanaflex with three refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants, Antispasticity/Antispasmodic Drugs, Tizanidine (.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63-66.

Decision rationale: CA MTUS recommends non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic lower back pain (LBP). Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. For this patient, submitted documentation does not identify acute exacerbation and does not show objective evidence of muscle spasm. Therefore, the medical necessity of tizanidine is not established.

Flexeril 10mg #90 with three refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for pain), Antispasmodics, Cyclobenzaprine.

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

Decision rationale: CA MTUS guidelines indicate that the use of cyclobenzaprine should be used as a short term therapy, and the effects of treatment are modest and may cause adverse effects. This patient had been using a muscle relaxant chronically which is longer than the recommended course of therapy of 2-3 weeks. There is no evidence in the documentation that suggests the patient experienced improvement with the ongoing use of cyclobenzaprine. Due to clear guidelines suggesting cyclobenzaprine as short term therapy and no clear benefit from adding this medication the requested prescription for cyclobenzaprine is not medically necessary.

Left L4-5 lumbar facet injection: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300-301, Table 12-8. Decision based on Non-MTUS Citation Official

Disability Guidelines, Facet joint medial branch blocks (therapeutic injections) and Facet joint intra-articular injections (therapeutic blocks)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back, Facet injections

Decision rationale: CA MTUS suggests that invasive techniques (e.g. local injections and facet-joint injections of cortisone and lidocaine) are of questionable merit. The ODG states that facet joint medial branch blocks are only recommended as a diagnostic tool for consideration of the facet joint as a pain source. The ODG states that diagnostic blocks are performed with the anticipation that if successful, treatment may proceed to facet neurotomy at the diagnosed levels. Treatment requires a diagnosis of facet joint pain. Criteria for facet joint pain are: Tenderness to palpation in the paravertebral areas (over the facet region); A normal sensory examination; Absence of radicular findings, although pain may radiate below the knee; and a normal straight leg raising exam. Injections should be limited to patients with low-back pain that is non-radicular and at no more than two levels bilaterally, and there is documentation of failure of conservative treatment (including home exercise, physical therapy (PT) and NSAIDs) prior to the procedure for at least 4-6 weeks. For this patient, physical exam findings are not consistent with facet mediated pain. Therefore, the medical necessity for a facet joint injection is not established.