

Case Number:	CM14-0166304		
Date Assigned:	10/28/2014	Date of Injury:	03/01/2012
Decision Date:	12/04/2014	UR Denial Date:	09/25/2014
Priority:	Standard	Application Received:	10/09/2014

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 Orthopedic Surgery and is licensed to practice in Texas. 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 injured worker is a 32-year-old female who reported an injury on 03/01/2012. Reportedly, the injured worker assisted a staff member in lifting their consumer from the floor into the wheelchair. While doing so, the injured worker made a quick unexpected rotation of her left side which caused her lower left lumbar injury. The injured worker's treatment history included chiropractic treatment, H-Wave device, medications, physical therapy sessions, and MRI of the lumbar spine, TENS unit, and Toradol injections. The injured worker was evaluated on 01/19/2014 and the provider documented he recommended the injured worker lose some weight. The provider requested Lidoderm patch for pain, Neurontin for numbness and tingling, Effexor for depression, Trazodone for depression and insomnia, and also requested physical therapy and acupuncture treatments, as well as a referral to a spine specialist. The diagnoses included LS Neurtis or Radiculitis, depression, single episode, severe, moderate, chronic pain, insomnia related to chronic pain, occupational problem, left S1 radiculopathy, L5-S1 central disc protrusion (5 mm) displacing left S1 nerve root, and chronic lumbar pain secondary to lumbar facet joint arthropathy. The Request for Authorization was not submitted for this review.

IMR ISSUES, DECISIONS AND RATIONALES

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

LidoPro Patch 5%, #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Salicylates, Topical Analgesics, Lidoderm Page(s): 105, 111, 112.

Decision rationale: The requested is not medically necessary. The California Medical Treatment Utilization Schedule (MTUS) guidelines state that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. The guidelines also state that any compounded product contains at least one drug (or drug class) that is not recommended. The guidelines state that there are no other commercially approved topical formulation of lidocaine (whether creams, lotions, or gels) that are indicated for neuropathic pain other than Lidoderm. The proposed ointment contains lidocaine. Furthermore, there was no documentation provided on conservative care measures such as physical therapy, pain management or home exercise regimen. Lidoderm Patches are recommended of a trial of first-line therapy however it is for diabetic neuropathy pain. The request that was submitted for review failed to indicate body location where topical patches are to be applied. As such, the request for LidoPro Patch 5%, #30 is not medically necessary.

Trazadone 50mg, #60: 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: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for Chronic Pain Page(s): 14-15.

Decision rationale: The requested is not medically necessary. California (MTUS) Chronic Pain Medical Guidelines recommends Trazodone as a selective serotonin and norepinephrine reuptake inhibitors (SNRIs) and FDA-approved for anxiety, depression, diabetic neuropathy, and Fibromyalgia. Used off-label for neuropathic pain and radiculopathy. Duloxetine is recommended as a first-line option for diabetic neuropathy. No high quality evidence is reported to support the use of duloxetine for lumbar radiculopathy. A systematic review indicated that tricyclic antidepressants have demonstrated a small to moderate effect on chronic low back pain (short-term pain relief), but the effect on function is unclear. This effect appeared to be based on inhibition of norepinephrine reuptake. SSRIs have not been shown to be effective for low back pain (there was not a significant difference between SSRIs and placebo) and SNRIs have not been evaluated for this condition. Reviews that have studied the treatment of low back pain with tricyclic antidepressants found them to be slightly more effective than placebo for the relief of pain. A non-statistically significant improvement was also noted in improvement of functioning. SSRIs do not appear to be beneficial. It is recommended that these outcome measurements should be initiated at one week of treatment with a recommended trial of at least 4 weeks. The request as submitted failed to indicate the injured worker's functional improvement and outcome measurements while taking trazodone. Additionally, the request that was submitted for review failed to include the frequency and duration of medication. As such, the request for Trazodone 50mg, #60 is not medically necessary.

Gabapentin 600mg, #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 Gabapentin (Neurontin) Page(s): 49.

Decision rationale: The request is not medically necessary. The California Medical Treatment Utilization Schedule (MTUS) Guidelines state that Gabapentin is an ant epilepsy drug (AEDs, also referred to as anticonvulsants), which has been shown to be effective for treatment of diabetic painful neuropathy and post herpetic neuralgia and has been considered as a first line treatment for neuropathic pain. The documentation submitted had lack of evidence of the efficacy of the requested drug after the injured worker takes the medication. In addition, the request did not include frequency of the medication. As such, the request for Gabapentin 600mg, #90 is not medically necessary.

Effexor 75mg, #60: 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 Venlafaxine (Effexor) Page(s): 123.

Decision rationale: The request for Effexor 75 mg is not medically necessary. Chronic Pain Medical Treatment guidelines recommends Venlafaxine as an option as an option in first-line treatment of neuropathic pain. Venlafaxine (Effexor) is a member of the selective-serotonin and norepinephrine reuptake inhibitor (SNRIs) class of antidepressants. It has FDA approval for treatment of depression and anxiety disorders. It is off label recommended for treatment of neuropathic pain, diabetic neuropathy, fibromyalgia, and headaches. The initial dose is generally 37.5 to 75 mg/day with a usual increase to a dose of 75 mg b.i.d or 150 mg/day of the ER formula. The maximum dose of the immediate release formulation is 375 mg/day and of the ER formula is 225 mg/day. It may have an advantage over tricyclic antidepressants due to lack of anticholinergic side effects. The request failed to include frequency and duration of medication. As such, the request for Effexor 75mg, #60 is not medically necessary.

Colace 100mg #60: 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 Laxative Opioids Page(s): 77.

Decision rationale: The requested is not medically necessary. California Medical Treatment Utilization Schedule recommends Colace for constipation. The injured worker is diagnosed with

constipation secondary to narcotics. The assumption that the injured worker will continue to have constipation with continued use of narcotics, supports the use of Colace. The provider failed to provide the rationale why the injured worker needs additional Colace. The request that was submitted failed to include duration and frequency of medication. As such, the request for Colace 100mg #60 is not medically necessary.

Spine Specialist x 1: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM, pg. 127 and Official Disability Guidelines (ODG)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Introduction Page(s): 1.

Decision rationale: The request for spine specialist X 1 is not medically necessary. The chronic pain medical treatment guidelines apply when the patient has chronic pain as determined by following the clinical topics section of the Medical Treatment Utilization Schedule (MTUS). In following the clinical topics section, the physician begins with an assessment of the presenting complaint and a determination as to whether there is a "red flag for a potentially serious condition" which would trigger an immediate intervention. Upon ruling out a potentially serious condition, conservative management is provided. If the complaint persists, the physician needs to reconsider the diagnosis and decide whether a specialist evaluation is necessary. If the patient continues to have pain that persists beyond the anticipated time of healing, without plans for curative treatment, such as surgical options, the chronic pain medical treatment guidelines apply. This provides a framework to manage all chronic pain conditions, even when the injury is not addressed in the clinical topics section of the MTUS. The request that was submitted for review failed to indicate the rationale upon the request for spine specialist x1. As such, the request for Spine Specialist x 1 is not medically necessary.

Eight (8) Acupuncture lumbar spine: 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: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: The request for acupuncture for the back X 6 sessions is not medically necessary. Per the Acupuncture Medical Treatment Guidelines, it is stated Acupuncture Medical Treatment Guidelines state that "acupuncture" is used as an option when pain medication is reduced or not tolerated; it may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. It is the insertion and removal of filiform needles to stimulate acupoints (acupuncture points). Needles may be inserted, manipulated, and retained for a period of time. Acupuncture can be used to reduce pain, reduce inflammation, increase blood flow, increase range of motion, decrease the side effect of medication-induced nausea, promote relaxation in an anxious patient, and reduce muscle spasm.

The guidelines state that the frequency and duration of acupuncture with electrical stimulation may be performed to produce functional improvement for up to 3 to 6 treatments no more than 1 to 3 times per week with a duration of 1 to 2 months. Acupuncture treatments may be extended if functional improvement is documented. The documentation submitted for review indicated the injured worker has already undergone conservative treatment such as physical therapy and chiropractic sessions; however, functional improvement was not noted. As such, the request for Eight (8) Acupuncture lumbar spine is not medically necessary.

Twelve (12) Physical Therapy lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

Decision rationale: The request is not medically necessary. The California MTUS Guidelines may support up to 10 visits of physical therapy for the treatment of unspecified myalgia and myositis to promote functional improvement. The injured worker has attended an unknown number of therapy sessions to date. There were no objective indications of progressive, clinically significant improvement from prior therapy. The provider failed to indicate long term functional goals. The documentation submitted for review indicated the injured worker has already undergone conservative treatment to include chiropractic sessions and physical therapy sessions. However, functional improvement was not noted. As such, the request for Twelve (12) Physical Therapy lumbar spine is not medically necessary. Additionally, the requested amount of visits will exceed the recommended amount per the guidelines.