

Case Number:	CM14-0170301		
Date Assigned:	10/20/2014	Date of Injury:	11/19/1999
Decision Date:	11/21/2014	UR Denial Date:	09/25/2014
Priority:	Standard	Application Received:	10/15/2014

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 Neurology 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 Injured Worker (IW) is a 71 year-old male with a date of injury noted as 11/19/1999. Records indicate that injuries to the IW's left and right knees and low back were sustained in activities he performed while working as a firefighter. Recent medical records indicate that the IW complains of low axial back pain; radiating pain to the left lower extremity (LLE) with numbness and tingling; an occasional left foot drop; daily muscle spasms; and poor sleep quality secondary to pain complaints. The diagnosis specific to the back complaints are multilevel degenerative disc disease, lumbar facet disease, and a left L5 radiculopathy. Physical examinations have remained unchanged from record-to-record over the past year and are notable for: a decreased lumbar range of motion limited by pain; hypertonicity, spasm, and tenderness on palpation of paravertebral muscles with a trigger point noted bilaterally; positive lumbar facet loading bilaterally, and positive Straight Leg Raising test on the left. Ankle jerk is repeatedly noted as 2/4 on the right and 0/4 on the left; motor strength is limited by pain; and sensory exam yields decreased light touch sensation over later foot and lateral calf on the LLE. The IW is being treated by a separate provider for the orthopedic concerns involving his knee injuries. Medical records show that the IW has had significant reduction in pain complaints from transforaminal epidural steroid injections (TFESI) and lumbar medial branch radiofrequency neurotomies. The most recent radiofrequency ablation (7/1/2014) provided 80% pain relief; the latest TFESI (9/23/2013) yielded 80% relief of LLE radicular pain for 6 months. Records reviewed indicate that the IW has been using Neurontin, Lidoderm Patches, Opioids (e.g., Avinza, Norco, and most recently Tramadol) for pain relief, Trazodone for insomnia, Zanaflex for muscle spasm, and Protonix for gastric symptoms which are stated to be secondary to Norco use. The history for each of these medications dates back to at least 10/12/2005. (Note: records indicate that since Tramadol had been substituted for Norco on 5/9/2014, the IW himself states

that Protonix is no longer necessary; see report dated 8/1/2014. Also noted is that the only Urine Toxicology screen reported was conducted 2/11/2011.) It is apparent from the records reviewed that the Lidoderm patches, Trazodone, Zanaflex, and Protonix were discontinued due to non-certification in May 2014 (see Progress Reports dated 3/14/2014 and 5/9/2014). Utilization Reviews specific to those previous requests were not included in the reports provided, however treatment plans and physician's notes in Progress Reports since 5/9/2014 indicate that the provider would continue to request authorization for these medications. A Utilization Review dated 9/25/2014 denied authorization for Lidoderm Patches 5% (qty #30), Zanaflex 4 mg (qty #60), Protonix 40 mg (qty #30), and Trazodone 50 mg (qty #60). A request for Neurontin 400 mg (qty# 120) was partially certified to qty #60 (for a trial of Neurontin increase from 400 mg three-times daily to four-times daily), and the request for Tramadol 50 mg (qty#90) was partially certified to qty# 68 (for the purpose of weaning). It is noted that the IW cannot tolerate Naprosyn, Diclofenac, and Celebrex and states he has allergic responses to sulfa medications and salicylates.

IMR ISSUES, DECISIONS AND RATIONALES

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

120 Neurontin 400 mg: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Epilepsy Drugs (AEDs) Section.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anticonvulsants, Antiepilepsy drugs Page(s): 16-18.

Decision rationale: Neurontin is the proprietary brand-name for Gabapentin. The MTUS indicates that Gabapentin is recommended as a first-line treatment for neuropathic pain (p. 18). Evidence has shown that gabapentin and gabapentin-like compounds may reduce the need for opioid treatment. While no specific imaging studies were provided for this review, the IW was given a diagnosis of multi-level degenerative disc disease and radiculopathy. The reported success from transforaminal steroid injections and medial branch radiofrequency ablations attest to the neuropathic pathology for the IW's pain complaints, and it is appropriate to continue use of Neurontin for pain relief as requested.

Lidoderm 5% patch, thirty count: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm (lidocaine patch) Page(s): 56-57.

Decision rationale: Lidoderm is the proprietary brand-name for a lidocaine patch. The MTUS indicates that this medication is FDA approved for treatment of localized peripheral pain secondary to post-herpetic neuralgia. There is not enough research to recommend this treatment

for other chronic neuropathic pain disorders. As this IW reports neuropathic pain complaints secondary to degenerative processes and not from post-herpetic neuralgia, medical necessity for Lidoderm patches is not substantiated.

Trazodone 50 mg, sixty count: Upheld

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

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: Where the MTUS is absent to comment regarding the use of tricyclics (e.g., amitriptyline, trazodone, mirtazapine) for the treatment of insomnia, the ODG indicates that such drugs have been used for that purpose due to their sedative effect. There is less evidence to support their use for treatment of insomnia but such drugs may be considered as an option for patients with coexisting depression. While Trazodone is frequently used for such indications, it is noted that tolerance to its sedative effects may develop, and rebound insomnia can occur once discontinued. Records provided for this review do not indicate that the IW reports depression. Further, physician's notes dating to at least 2012 state that the IW reports poor quality of sleep, even as Trazodone had been continually used since at least 10/12/2005. It is not apparent that this medication had alleviated the IW's report of poor sleep, which has become standard to note in nearly every medical report provided for review. As there are no reports of diagnosed depression, and as it appears that the patient may have in fact developed tolerance to the effects of this medication, medical necessity for continued use of Trazodone has not been substantiated.

Tramadol HCL, ninety count: Upheld

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

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

Decision rationale: Tramadol is a centrally acting synthetic opioid. The MTUS states that opioids may be considered for treatment of neuropathic pain which has not responded to first-line therapeutics, such as tricyclic antidepressants or anticonvulsants (e.g., gabapentin). It may be recommended for treatment of episodic exacerbations of severe pain or for prompt relief of pain during the titration phase of first-line recommended drugs. However, there have been few trials of repeated-dose opioids for the treatment of neuropathy secondary to lumbar radiculopathy or the treatment of chronic lumbar root pain (Opioids, pp. 82-83). Further, the efficacy of long-term opioid treatment appears to be limited in treatment of chronic back pain (p. 80). The MTUS cites a recent study which indicates that tricyclic antidepressants and opioids used in doses found to effectively treat painful diabetic neuropathy or post-herpetic neuralgia were not effective in reducing pain complaints due to chronic lumbar radiculopathy. As the records

indicate that the IW suffers from chronic low back pain with significant radicular pain symptoms, it is not apparent that continued opioid treatment for these complaints is appropriate. Medical records indicate that the IW has been prescribed Gabapentin and opioids concurrently since at least 10/12/2005, but there are no details provided to substantiate that the opioid treatment has in fact provided measurable improvements in functional capacity; there are no notes of pain assessment specific to evaluate opioid-efficacy, such as intensity of pain before and after dosing, time-to-relief after dosing, and duration of symptom relief - outcome measures recommended by the MTUS (p. 81) which should be evaluated when considering the continued-use of opioids. Records indicate that the IW has been using opioid chronically, as indicated by the continued renewal of prescriptions at each clinical encounter dating to 5/9/2014. Routine urine toxicology screens providing evidence that the IW is using the opioid medications appropriately are not present in the records: in nine years of opioid use there is only one report of a urine drug screen. As the previous utilization reviewer certified a limited supply of Tramadol for the purpose of weaning, it is not medically necessary to recommend authorization for this medication in any supply.

Protonix 40 mg, thirty count: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation University of Michigan Health System, Gastroesophageal Reflux Disease (GERD), Ann Arbor, MI, 2012, May, page 12 (11 references)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68.

Decision rationale: Where there is a gastrointestinal risk for an adverse event, the MTUS Chronic Pain Management Treatment Guidelines recommends use of a proton pump inhibitor, such as Protonix. In this case, however, reports do not cite that this IW has any of the risk factors (i.e., age over 65 years, history of peptic ulcer, concurrent use of ASA, corticosteroids and/or anticoagulants nor high-dose/multiple NSAIDs use) which would warrant medical necessity of a proton pump inhibitor (MTUS Guidelines, NSAIDs, GI symptoms & cardiovascular risk, p. 68). Furthermore, physician's notes indicate that the IW has discontinued use of Protonix and that the IW has found it to be no longer necessary. Protonix is not medically necessary.

Zanaflex 4 mg, sixty count: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for Pain) Section.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63-64.

Decision rationale: The MTUS Guidelines indicate that non-sedating muscle relaxants may be used with caution for short-term treatment of acute exacerbations in patients with chronic low back pain (Muscle Relaxants, pp. 63-64). Even so, efficacy seems to diminish with prolonged

use and may lead to dependency in some cases. Zanaflex is an antispasmodic/antispasticity alpha2-adrenergic agonist that the FDA has approved for management of spasticity but is not labeled for low back pain. It is apparent from the records provided (dating from 5/12/2005) that the IW has been utilizing Zanaflex on a prolonged, chronic basis, noting re-fills have been consistently requested which would indicate its use by the IW twice daily for nearly nine years. Such use is not considered short-term treatment for acute exacerbations; the possibility that the IW's prolonged use has resulted in diminished efficacy of or dependence on this medication should be taken under consideration. Medical necessity is not substantiated for the continued use of this medication.