

Case Number:	CM14-0039284		
Date Assigned:	08/01/2014	Date of Injury:	12/29/2003
Decision Date:	08/29/2014	UR Denial Date:	02/27/2014
Priority:	Standard	Application Received:	04/03/2014

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 Internal 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 an injured worker with lumbar facet syndrome, spinal lumbar degenerative disc disease, and low back pain. The date of injury was 12/29/2003. The progress report dated February 04, 2014 was provided by [REDACTED]. The subjective complaints were back pain radiating from low back down left leg and lower backache. The current medications were Ultram ER 300 mg daily, Norco 10-325 mg four times a day, Lidoderm 5% patches, Flexeril 5 mg twice daily, Rozerem 8 mg at bedtime as needed, Ambien CR 12.5 mg at bedtime as needed, Toprol XL 50 mg daily. Physical exam was documented. The patient's blood pressure was 160/78. The patient appeared to be well nourished, well developed, calm and in mild pain. She did not show signs of intoxication or withdrawal. The patient has antalgic gait; has slowed gait; has stooped gait; doesn't use assistive devices. Lumbar spine had no scoliosis, asymmetry or abnormal curvature noted on inspection of the lumbar spine. The patient's range of motion is restricted with flexion limited to 65 degrees limited by pain, extension limited to 5 degrees limited by pain, right lateral bending limited to 15 degrees limited by pain and left lateral bending limited to 15 degrees limited by pain but normal lateral rotation to the left and lateral rotation to the right. On palpation, paravertebral muscles, hypertonicity, spasm, tenderness. Lumbar facet loading is positive on both the sides. Straight leg raising test is positive on the left side in supine position at degrees. Ankle jerk is 2/4 on the right side and 1/4 on the left side. Patellar jerk is 2/4 on the right side and 1/4 on the left side. On examination of higher functions, she is conscious; mental status is normal; she has normal immediate, recent and remote memory; alert and oriented times four without evidence of somnolence. Motor strength of extensor hallucis longus muscle is 4/5 on both sides, ankle dorsi flexor is 5/5 on both sides, knee extensor is 5/5 on both sides, knee flexor is 5/5 on both sides, and hip flexor is 5/5 on both sides. On examination of deep tendon reflexes, knee jerk is 2/4 on both sides; ankle jerk is 2/4 on both sides. There is no evidence of

edema. The diagnoses were lumbar facet syndrome, spinal lumbar degenerative disc disease, and low back pain. The patient has completed physical therapy. The MRI of the lumbar spine that was performed on 11/12/2008 reported degeneration of the L3-L4 and L4-L5 discs with posterior element hypertrophic changes, mild spinal stenosis at L4-L5, and minimal stenosis. The treatment plan included physical therapy and medications. The Utilization Review decision date was 02/27/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lidoderm 5% #30 with 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm (Lidocaine patch). Decision based on Non-MTUS Citation Official Disability Guidelines, Pain (Chronic), Criteria for the use of Lidoderm patches.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm (Lidocaine patch), Topical Analgesics Page(s): 56-57, 111-112.

Decision rationale: The MTUS Chronic Pain Medical Treatment Guidelines states that Lidoderm is not a first-line treatment and is only FDA approved for post-herpetic neuralgia. Further research is needed to recommend Lidoderm for chronic neuropathic pain disorders other than post-herpetic neuralgia. Lidoderm is not recommended for non-neuropathic pain. The patient is an injured worker with lumbar facet syndrome, spinal lumbar degenerative disc disease, and low back pain. Medical records do not document a diagnosis of post-herpetic neuralgia. Per MTUS guidelines, Lidoderm is only FDA approved for post-herpetic neuralgia, and is not recommended for other chronic neuropathic pain disorders or non-neuropathic pain. Medical records and MTUS guidelines do not support the medical necessity of Lidoderm patch. Therefore, the request for Lidoderm 5% #30 with 1 refill is not medically necessary.

Rozerem 8mg #30 with 1 refill: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Clinical Guideline for the Evaluation and Management of Chronic Insomnia in Adults. J Clin Sleep Med 2008 Oct 15.

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

Decision rationale: The California MTUS does not address Rozerem (Ramelteon). The Official Disability Guidelines (ODG) states that Rozerem is for short-term (7-10 days) use only. Progress reports document that Rozerem (Ramelteon) was prescribed 10-15-2013, 12-10-2013, and 02-04-2014. The Official Disability Guidelines do not recommend the use of Rozerem long-term. Medical records do not support the use of Rozerem long-term. Therefore, the request for Rozerem 8mg #30 with 1 refill is not medically necessary.

Flexeril 5mg #60 with 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril, Amrix, Fexmid, generic available).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47, 49, Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril), Muscle relaxants Page(s): 41-42, 63-66.

Decision rationale: The MTUS addresses muscle relaxants. American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) states that muscle relaxants seem no more effective than NSAIDs for treating patients with musculoskeletal problems, and using them in combination with NSAIDs has no demonstrated benefit. Muscle relaxants may hinder return to function by reducing the patient's motivation or ability to increase activity. Table 3-1 states that muscle relaxants are not recommended. Chronic Pain Medical Treatment Guidelines addresses muscle relaxants. Muscle relaxants should be used with caution as a second-line option for short-term treatment. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. According to a review in American Family Physician, muscle relaxants should not be the primary drug class of choice for musculoskeletal conditions. Chronic Pain Medical Treatment Guidelines state that Cyclobenzaprine (Flexeril) is an option for a short course of therapy. Treatment should be brief. The addition of cyclobenzaprine to other agents is not recommended. FDA guidelines state that Cyclobenzaprine is indicated for acute musculoskeletal conditions. Cyclobenzaprine should be used only for short periods (up to two or three weeks) because adequate evidence of effectiveness for more prolonged use is not available. The patient is an injured worker with lumbar facet syndrome, spinal lumbar degenerative disc disease, and low back pain. The date of injury was 12-29-2003. The occupational injuries are not acute conditions. MTUS, ACOEM, and FDA guidelines do not support the use of Fexmid (Cyclobenzaprine) for chronic conditions. Therefore, the request for Flexeril 5mg #60 with 1 refill is not medically necessary.

Norco 10/325mg with 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Hydrocodone/Acetaminophen (Norco).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47-48, Chronic Pain Treatment Guidelines Opioids, Opioids for chronic pain Page(s): 74-96, 80.

Decision rationale: The MTUS Chronic Pain Medical Treatment Guidelines state that for chronic back pain, opioids are limited for short-term pain relief, and long-term efficacy is unclear and appears limited. American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) Chapter 3 states that opioids appear to be no more effective than safer analgesics for managing most musculoskeletal symptoms. Opioids should be used only if needed for severe pain and only for a short time. ACOEM guidelines state that the long-term use of

opioids is not recommended for low back conditions. The patient is an injured worker with lumbar facet syndrome, spinal lumbar degenerative disc disease, and low back pain. The date of injury was 12-29-2003. The patient has chronic back conditions. Medical records indicate that the patient has used opioids long-term. MTUS and ACOEM guidelines do not support the long-term use of opioids for low back conditions. Therefore, the request for Norco 10/325mg with 1 refill is not medically necessary.

Ambien CR 12.5mg #20 with 1 refill: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain (Chronic), Zolpidem (Ambien).

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

Decision rationale: The MTUS does not address Ambien. The Official Disability Guidelines (ODG) states that Ambien is approved for the short-term, usually two to six weeks, treatment of insomnia, and should be used for only a short period of time. Progress reports document that Ambien was prescribed on 10-15-2013, 12-10-2013, and 02-04-2014. The Official Disability Guidelines states that Ambien should be used for only a short period of time. Long-term use of Ambien is not recommended. Therefore, the request for Ambien CR 12.5mg #20 with 1 refill is not medically necessary.

Ultram ER 300mg #15 with 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Ultram (Tramadol).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47-48, Chronic Pain Treatment Guidelines Opioids, Opioids for chronic pain Page(s): 74-96, 80.

Decision rationale: The MTUS Chronic Pain Medical Treatment Guidelines state that for chronic back pain, opioids are limited for short-term pain relief, and long-term efficacy is unclear and appears limited. American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) Chapter 3 states that opioids appear to be no more effective than safer analgesics for managing most musculoskeletal symptoms. Opioids should be used only if needed for severe pain and only for a short time. ACOEM guidelines state that the long-term use of opioids is not recommended for low back conditions. The patient is an injured worker with lumbar facet syndrome, spinal lumbar degenerative disc disease, and low back pain. The date of injury was 12-29-2003. The patient has chronic back conditions. Medical records indicate that the patient has used opioids long-term. MTUS and ACOEM guidelines do not support the long-term use of opioids for low back conditions. Therefore, the request for Ultram ER 300mg #15 with 1 refill is not medically necessary.

TENS unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS, chronic pain (transcutaneous electrical nerve stimulation).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300 308-310, Chronic Pain Treatment Guidelines TENS, chronic pain (transcutaneous electrical nerve stimulation), Transcutaneous electrotherapy, Electrical stimulators (E-stim), Functional restoration programs (FRPs) Page(s): 114-117, 45, 49.

Decision rationale: The MTUS addresses transcutaneous electrical nerve stimulation (TENS). American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) Chapter 12 Low Back Complaints (Table 12-8) Summary of Recommendations for Evaluating and Managing Low Back Complaints (Page 308) states that TENS units are not recommended for low back conditions. ACOEM 2nd Edition Chapter 12 Low Back Complaints (Page 300) states that physical modalities, such as transcutaneous electrical neurostimulation (TENS) units, have no proven efficacy in treating acute low back symptoms. Insufficient scientific testing exists to determine the effectiveness of these therapies. The MTUS Chronic Pain Medical Treatment Guidelines state that TENS does not appear to have an impact on perceived disability or long-term pain. Several published evidence-based assessments of transcutaneous electrical nerve stimulation (TENS) have found that evidence is lacking concerning effectiveness. TENS is not recommended as a primary treatment modality, but TENS may be considered as an option, if used as an adjunct to an evidence-based functional restoration programs (FRP) for the conditions described below. Complex regional pain syndrome CRPS I, CRPS II, diabetic neuropathy, post-herpetic neuralgia, phantom limb pain, spasticity in spinal cord injury, multiple sclerosis are the conditions that may be consider according to MTUS guidelines. Criteria for TENS use requires documentation of chronic intractable pain for the conditions noted above. Medical records do not document enrollment in an evidence-based functional restoration program (FRP), which is an MTUS requirement for TENS. Medical records do not document the diagnoses CRPS I, CRPS II, diabetic neuropathy, post-herpetic neuralgia, phantom limb pain, spasticity in spinal cord injury, multiple sclerosis, which are the conditions that merit consideration for TENS, according to MTUS guidelines. Therefore, medical records do not support the medical necessity of TENS, in accordance with MTUS guidelines. Medical records document that the patient is an injured worker with lumbar facet syndrome, spinal lumbar degenerative disc disease, and low back pain. Transcutaneous electrical nerve stimulation (TENS) is not recommended by the American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) for low back conditions. Therefore, the request for TENS unit is not medically necessary.