

Case Number:	CM14-0043815		
Date Assigned:	08/11/2014	Date of Injury:	05/12/2003
Decision Date:	09/11/2014	UR Denial Date:	03/06/2014
Priority:	Standard	Application Received:	03/17/2014

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 50-year-old male who has submitted a claim for L4-5, L5-S1 degenerative discopathy with facet syndrome, sleep disturbance, depression, and obesity associated with an industrial injury date of 05/12/2003. Medical records from 08/06/2013 to 03/06/2014 were reviewed and showed that patient complained of low back pain graded 8/10 with radiation to left lower extremity and neck pain graded 5/10. Physical examination revealed antalgic gait on the left side and abnormal heel and toe walk on the left side. Tenderness over the left lumbar paraspinal muscles and bilateral sacroiliac area were noted. Lumbar range of motion was decreased in all planes. SLR test was positive at 60 degrees (supine) and 50 degrees (seated). Sensation to pin was decreased over left dorsum and posterolateral calf. MMT was decreased on left plantar flexors and toe extensors (both 4/5). DTRs were decreased for both ankles bilaterally. Of note, the patient's review of systems (02/07/2014) revealed heartburn, rectal bleeding, depression, and nervousness. Urine toxicology review dated 10/28/2013 showed Gabapentin (prescribed), Sertraline (not prescribed), and Zolpidem (not prescribed). Treatment to date has included physical therapy, aquatic therapy, Vitamin B injection (05/10/2013), Tizanidine 4mg (DOS: 02/07/2014), Alprazolam 1mg (DOS: 02/07/2014), Zolpidem 10mg (DOS: 02/07/2014), Omeprazole 20mg #100 (DOS: 10/28/2013), Norco 10/325 mg (DOS: 10/28/2013) and Gabapentin 600mg (DOS: 02/07/2014). Utilization review dated 03/06/2014 denied the request for Toradol injection of 2cc because the patient was complaining of severe chronic pain in lower back and does not appear to have a recent trauma. Utilization review dated 03/06/2014 denied the request for retrospective request of 1 intramuscular injection of vitamin B12 complex because there were no clinical findings consistent with vitamin B12 deficiency. Utilization review dated 03/06/2014 denied the request for Tizanidine 4mg with 3 refills because the prolonged use of this medication was not supported by the guidelines. Utilization review dated

03/06/2014 certified the request for Gabapentin 600mg #120 with 3 refills because the patient has complained of current radicular pain with history of success from prior Gabapentin use. Utilization review dated 03/06/2014 modified the request for Norco 10/325mg #90 with 3 refills to 45 tablets for the purpose of weaning. Utilization review dated 03/06/2014 certified the request for Omeprazole 20mg #60 because the patient had heartburn and rectal bleeding. Utilization review dated 03/06/2014 denied the request for Alprazolam ER 1mg #30 with 3 refills because synergistic action of this medication with opioids leads to dependence. Utilization review dated 03/06/2014 denied the request for Zolpidem 10mg #30 with 3 refills because the inherent risks in long-term use of Zolpidem outweigh potential benefits. Utilization review dated 03/06/2014 denied the request for Amitramadol-DM transderm 240gm due to the lack of evidence based support for use of these medications. Utilization review dated 03/06/2014 denied the request for Gabapentin 6%/Ketoprofen 20%/Lidocaine HCL 6.15% due to lack of guidelines support for efficacy and safety of this compounded medication. Utilization review dated 03/06/2014 certified the request for one urinalysis drug screening because the patient was at intermediate risk for drug dependence.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 INTRAMUSCULAR INJECTION OF TORADOL 2CC: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 72.

Decision rationale: According to CA MTUS Chronic Pain Treatment Guidelines, Ketorolac (Toradol , generic available) 10 mg is not indicated for minor or chronic painful conditions. According to ODG pain Chapter, Ketorolac [Boxed Warning] may be used as an alternative to opioid therapy when administered intramuscularly. The FDA boxed warning would relegate this drug to second-line use unless there were no safer alternatives. In this case, the patient complained of chronic back pain. Recent medical records did not document recent trauma or acute exacerbation of back pain. The guidelines do not recommend the use of Toradol for chronic painful conditions. There was no discussion as to why variance from the guidelines is needed. Therefore, the request for Intramuscular Injection of Toradol 2cc is not medically necessary.

1 INTRAMUSCULAR INJECTION OF VITAMIN B12 COMPLEX-NON-CERTIFIED: 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, Vitamin B.

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, Official Disability Guidelines (ODG) Pain chapter, was used instead. ODG states that "Vitamin B is not recommended." It is frequently used for treating peripheral neuropathy but its efficacy is not clear. In this case, the patient received a previous Vitamin B12 Injection (05/10/2013) with no documentation of functional improvement. There was no clear indication for retrospective use of Vitamin B12 Injection which was not in conjunction with guidelines recommendation. Therefore, the request for Intramuscular Injection of Vitamin B12 Complex is not medically necessary.

Tizanidine 4mg w/ 3 refills: Upheld

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

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

Decision rationale: As stated on pages 63 and 66 of the CA MTUS Chronic Pain Medical Treatment Guidelines, Tizanidine is a centrally acting alpha2-adrenergic agonist that is FDA approved for management of spasticity and off label use for low back pain. Acetaminophen and NSAIDs remain the first-line drugs for chronic pain. In most LBP cases, they show no benefit beyond NSAIDs in pain and overall improvement. Also there is no additional benefit shown in combination with NSAIDs. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. In this case, the patient was prescribed Tizanidine 4mg since 02/07/2014. There was no documentation of functional improvement with drug use. Furthermore, there is no clear indication for long-term use of Tizanidine which is not in conjunction with guidelines recommendation. Therefore, the request for Tizanidine 4mg with 3 refills is not medically necessary.

Norco 10/325mg Qty 90 w/3 Refills: Upheld

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): 78.

Decision rationale: According to page 78 of the CA MTUS Chronic Pain Medical Treatment Guidelines state that "ongoing opioid treatment should include monitoring of analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors; these outcomes over time should affect the therapeutic decisions for continuation." There was no documentation of

pain relief, functional improvement, and recent urine toxicology review, which are required to support continued use of opiates. In this case, the patient was prescribed Norco 10/325mg since 10/28/2013. However, there was no documentation of pain relief or functional improvement, which is required by the guidelines prior to continuation of opiate use. Therefore, the request for Norco 10/325mg #90 with 3 refills is not medically necessary.

Alprazolam Er 1mg Qty 30 w/3 Refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines benzodiazepines Page(s): 24.

Decision rationale: As stated on page 24 of the California MTUS Chronic Pain Medical Treatment Guidelines, Benzodiazepines are not recommended for long-term use because of unproven long-term efficacy and risk of dependence; use is limited to 4 weeks. In this case, the patient has been prescribed Alprazolam 1mg since 02/07/2014 with no documentation of pain relief. There is no clear indication for the use of Benzodiazepines beyond 4 weeks, which is not recommended by the guidelines. Therefore, the request for Alprazolam ER 1mg #30 with 3 refills is not medically necessary.

Zolpidem 10mg Qty 30 w/3 Refills: Upheld

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

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 Zolpidem. 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 states that "Zolpidem (Ambien) is a prescription short-acting non-benzodiazepine hypnotic, which is approved for the short-term (usually two to six weeks) treatment of insomnia. While sleeping pills are commonly prescribed in chronic pain, pain specialists rarely, if ever, recommend them for long-term use. They can be habit-forming and they may impair function and memory. There is also concern that they may increase pain and depression over the long term." In this case, the patient was prescribed Zolpidem 10mg since 02/07/2014. There was no documentation of response to Zolpidem use. The guidelines only recommend the use of Zolpidem for duration of two to six weeks. The medical necessity for continuation of Zolpidem use has not been established. Therefore, the request for Zolpidem 10mg #30 with 3 refills is not medically necessary.

Amitramadol-DM transderm 240gm: 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): 111-113.

Decision rationale: CA MTUS Chronic Pain Treatment Guidelines state that "Topical analgesics are largely experimental in use with few randomized controlled trials to determine safety or efficacy." Amitriptyline is a tricyclic antidepressant considered first-line agents, but there is no discussion regarding topical application of this drug. Regarding Tramadol, the topical formulation of Tramadol does not show consistent efficacy. Guidelines provide no evidence-based recommendations regarding the use of Topical Dextromethorphan. Furthermore, the use of these compounded agents requires knowledge of the specific analgesic effect of each agent and how it will be useful for the specific therapeutic goal required. In this case, the compounded cream contains Amitriptyline, Tramadol, and Dextromethorphan which all have unknown specific analgesic effect. Furthermore, the exact content of the compounded cream was not stated. The medical necessity for use of the compounded cream cannot be established. Therefore, the request for Amitramadol-DM Transderm 240gm is not medically necessary.

Gabapentin 6% / Ketoprofen 20% / Lidocaine HCl 6.15% transderm, 240gm: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: As noted on pages 111-113 of the California MTUS Chronic Pain Medical Treatment Guidelines, any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. There is little to no research to support the use of Lidocaine for compounded products, and Lidocaine is not recommended for topical use. Gabapentin is not recommended for topical applications. Ketoprofen is not recommended for topical use as there is a high incidence of photo contact dermatitis. In this case, the compounded cream contains Gabapentin, Ketoprofen, and Lidocaine which are not recommended by the guidelines for topical use. Therefore, the request for Gabapentin 6% / Ketoprofen 20% / Lidocaine HCL 6.15% transderm, 240gm is not medically necessary.