

Case Number:	CM14-0045778		
Date Assigned:	07/02/2014	Date of Injury:	12/26/2008
Decision Date:	08/21/2014	UR Denial Date:	03/31/2014
Priority:	Standard	Application Received:	04/14/2014

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 Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in Tennessee. 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 55-year-old male who has submitted a claim for right lumbar radiculopathy secondary to lumbar disc injuries at L4-L5 and L5-S1, depression related to chronic pain syndrome, and abdominal pain consistent with prior use of non-steroidal anti-inflammatory medications, status post lumbar laminectomy and discectomy at L5-S1; associated with an industrial injury date of 12/26/2008. Medical records from 2012 to 2014 were reviewed and showed that patient complained of persistent low back pain radiating down into the right leg. Physical examination showed tenderness over the right lumbar paravertebral and gluteal muscles. Range of motion of the lumbar spine was limited. Straight leg raise test was positive on the right. Hyporeflexia was noted in the bilateral lower extremities, and the right Achilles reflex was absent. Weakness was noted in the right anterior tibialis, gastrocnemius, and extensor hallucis longus. Sensory deficits were noted along the right L4-L5 and S1 dermatomes. MRI of the lumbar spine, dated 08/07/2012, showed recurrent disc herniation at L5-S1 with moderate bilateral foraminal stenosis at L4-L5 and right L5-S1. EMG of the lower extremities, dated 07/20/2011, showed subacute chronic right L5 radiculopathy. The official reports of the imaging and electrodiagnostic studies were not provided for review. Treatment to date has included medications, physical therapy, epidural steroid injection, and surgery as stated above. Utilization review, dated 03/31/2014, denied the request for epidural steroid injections because there was no documentation regarding amount and duration of pain reduction, return to work, or reduction of medication use; denied the request for Fexmid because guidelines do not recommend its prolonged use; modified the request for Celexa because SSRIs have a role in treating secondary depression; and denied the request for Dendracin lotion because there is no indication that an increased formulation of capsaicin would provide further efficacy, and the patient continues to be treated with oral medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

Transforaminal Epidural Steroid Injections at Right L4-5 and L5-S1: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs) Page(s): 46.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injection Page(s): 46.

Decision rationale: As stated on page 46 of the CA MTUS Chronic Pain Medical Treatment Guidelines, epidural steroid injections (ESI) are recommended as an option for treatment of radicular pain. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. Also, the patient must be initially unresponsive to conservative treatment. Repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for 6 to 8 weeks. In this case, the patient complains of back pain accompanied by radicular symptoms despite medications and previous ESI on 11/14/2012 which provided greater than 50% pain relief and reduction in medication intake for at least 6 weeks. Physical examination showed positive straight leg raise test, and neurologic deficits along the L4-L5 and L5-S1 dermatomal distributions. MRI of the lumbar spine, dated 08/07/2012, showed recurrent disc herniation at L5-S1 with moderate bilateral foraminal stenosis at L4-L5 and right L5-S1. EMG of the lower extremities, dated 07/20/2011, showed subacute chronic right L5 radiculopathy. The criteria for ESI have been met. Therefore, the request for TRANSFORAMINAL EPIDURAL STEROID INJECTIONS AT RIGHT L4-5 AND L5-S1 is medically necessary.

Fexmid 7.5mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63.

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

Decision rationale: Cyclobenzaprine is a skeletal muscle relaxant and a central nervous system depressant. As stated on page 41 of CA MTUS Chronic Pain Medical Treatment Guidelines, treatment using cyclobenzaprine should be used as a short course of therapy because the effect is modest and comes at the price of greater adverse effects. The effect is greatest in the first 4 days of treatment. In this case, the patient has been prescribed Fexmid since at least November 2012. However, long-term use of Fexmid is not recommended. Therefore, the request for FEXMID 7.5 MG #60 is not medically necessary.

Celexa 10mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines SSRIs (selective serotonin reuptake inhibitors) Page(s): 107.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness & Stress chapter, Antidepressants for treatment of MDD (major depressive disorder).

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, ODG was used instead. According to ODG, antidepressants are recommended for initial treatment of presentations of Major Depressive Disorder (MDD) that are moderate, severe, or psychotic, unless electroconvulsive therapy is part of the treatment plan. In this case, the patient was prescribed citalopram since at least 2012 for depression, and reported significant improvement of depression and pain. However, there is no documentation regarding the patient's depressive symptoms, or the severity of depression. Lastly, the present request as submitted failed to specify the quantity to be dispensed. Therefore, the request for CELEXA 10 MG is not medically necessary.

Dendracin lotion, 120mL: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 112-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain chapter, Salicylate topicals.

Decision rationale: As stated on pages 112 to 113 of the CA MTUS Chronic Pain Medical Treatment Guidelines, topical analgesics are recommended as an option as indicated below. Largely experimental in use with few randomized controlled trials to determine efficacy or safety. These agents are applied locally to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Dendracin contains Methyl salicylate/capsaicin 0.0375%/Menthol. Regarding the capsaicin component, the CA MTUS states that there is no current indication that an increase over a 0.025% formulation would provide any further efficacy. In addition, the FDA has issued an alert in 2012 indicating that topical OTC pain relievers that contain menthol, methyl salicylate, or capsaicin, may in rare instances cause serious burns. In this case, the patient has been prescribed Dendracin since at least 2012. However, guidelines do not support the use of Dendracin because all of its components are not recommended. Furthermore, the medical records submitted for review did not show evidence of intolerance to or failure of oral analgesics to warrant the use of topical formulations. Therefore, the request for DENDRACIN LOTION 120 ML is not medically necessary.