

Case Number:	CM14-0055290		
Date Assigned:	07/07/2014	Date of Injury:	10/01/2003
Decision Date:	09/09/2014	UR Denial Date:	04/01/2014
Priority:	Standard	Application Received:	04/24/2014

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 Preventative Medicine has a subspecialty in Occupational Medicine and is licensed to practice in Iowa. 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:

This patient is a 61 year old employee with date of injury of 10/1/2003. Medical records indicate the patient is undergoing treatment for lumbar post laminectomy syndrome. Her diagnoses include lumbar disc degeneration and lumbar radiculopathy, failed surgery syndrome, s/p lumbar fusion and chronic pain with lactogenic opioid dependency and s/p intrathecal morphine pump trial; end of service life, intrathecal pump; (pump implanted in 2006). Subjective complaints include chronic low back pain with bilateral lower extremity radiation. Objective findings include spasm in the paraspinous musculature of the lumbar spine; range of motion (ROM) of the lumbar spine was severely limited secondary to pain. Pain increased with flexion and extension. The patient had decreased sensitivity along the L5-S1 dermatome in both lower extremities. The patient had arrived at the exam in moderate distress with a slow and antalgic gait. She uses a cane to ambulate. Treatment has consisted of Baclofen, Elavil, Vicodin, Xanax, morphine pump, Demerol, Ambien, Fosamax, Vicodin ES, aspirin, Transecon, Lasix, cyclobenzaprine, lidocaine patch, Restone and hydrocone. The utilization review determination was rendered on 4/1/2014 recommending non-certification of Cyclobenzaprine 7.5mg #90, Hydrocodone 5-325mg # 90, Lidocaine 5% Patch and Restone 3-100mg #3.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cyclobenzaprine 7.5mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine, Medications for chronic pain, Antispasmodics Page(s): 41-42, 60-61, 64-66. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Cyclobenzaprine (Flexeril®) Other Medical Treatment Guideline or Medical Evidence: UpToDate, Flexeril.

Decision rationale: Additionally, MTUS outlines that, "Relief of pain with the use of medications is generally temporary, and measures of the lasting benefit from this modality should include evaluating the effect of pain relief in relationship to improvements in function and increased activity. Before prescribing any medication for pain the following should occur: (1) determine the aim of use of the medication; (2) determine the potential benefits and adverse effects; (3) determine the patient's preference. Only one medication should be given at a time, and interventions that are active and passive should remain unchanged at the time of the medication change. A trial should be given for each individual medication. Analgesic medications should show effects within 1 to 3 days, and the analgesic effect of antidepressants should occur within 1 week. A record of pain and function with the medication should be recorded. (Mens, 2005)" Uptodate "flexeril" also recommends "Do not use longer than 2-3 weeks". Medical documents do not fully detail the components outlined in the guidelines above and do not establish the need for long term/chronic usage of cyclobenzaprine. As such, the request for Cyclobenzaprine 7.5mg #90 is not medically necessary and appropriate.

Hydrocodone 5-325mg # 90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Ongoing Management Page(s): 78.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), Opioids, Pain.

Decision rationale: ODG does not recommend the use of opioids for low back pain "except for short use for severe cases, not to exceed 2 weeks." The patient has exceeded the 2 week recommended treatment length for opioid usage. MTUS does not discourage use of opioids past 2 weeks, but does state that "ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life." The treating physician does not fully document the least reported pain over the period since last assessment, intensity of pain after taking opioid, pain relief, increased level of function, or improved quality of life. Additionally, medical documents indicate that the patient has been on multiple oral opioids and has a history of opioid dependence. The utilization reviewer on 4/1/14 recommended 20% weaning of Hydrocodone 5-

325mg # 90. As such, the question for Hydrocodone 5-325mg # 90 is not medically necessary and appropriate.

Lidocaine 5% Patch: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm patches Page(s): 56-57. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: UpToDate.com, Lidocaine (topical).

Decision rationale: Chronic Pain Medical Treatment Guidelines state, "Lidoderm is the brand name for a lidocaine patch produced by [REDACTED]. Topical lidocaine may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). This is not a first-line treatment and is only FDA approved for post-herpetic neuralgia. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than post-herpetic neuralgia. Formulations that do not involve a dermal-patch system are generally indicated as local anesthetics and anti-pruritics. For more information and references, see Topical analgesics." Medical documents provided do not indicate that the use would be for post-herpetic neuralgia. Additionally, treatment notes do not detail the other first-line therapy used (anti-depressants, gabapentin, etc.) and what clinical outcomes resulted. As such, the request for Lidoderm 5% patches are not medically necessary and appropriate.

Restone 3-100mg #30: 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) Treatment in Workers Compensation/Pain; regarding insomnia.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain, Insomnia; Mental Stress, Insomnia, and Medical food Other Medical Treatment Guideline or Medical Evidence:

<http://bioportal.bioontology.org/ontologies/RXNORM?p=classes&conceptid=http%3A%2F%2Fpurl.bioontology.org%2Fontology%2FRXNORM%2F435493>.

Decision rationale: Restone is composed of melatonin and tryptophan. ODG does recommend melatonin for insomnia. However, tryptophan is considered a medical food. ODG states that a medical food is "a food which is formulated to be consumed or administered enterally under the supervision of a physician and which is intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements, based on recognized scientific principles, are established by medical evaluation". Medical documents do not establish deficiency in nutritional requirements and do not indicate how the requested medication would specifically address the deficiency. In addition the treating physician has not documented the patient's sleep

hygiene or improvement in sleep on set, sleep quality, and next day functioning with Restone. As such the request for Restone 3-100mg #30 is not medically necessary and appropriate.