

Case Number:	CM14-0059738		
Date Assigned:	08/08/2014	Date of Injury:	04/05/2013
Decision Date:	11/25/2014	UR Denial Date:	04/18/2014
Priority:	Standard	Application Received:	04/30/2014

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 Anesthesia, has a subspecialty in Acupuncture & Pain 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:

60 year old female injured worker with date of injury 4/5/13 has related back, neck and shoulder pain. Per progress report dated 4/8/14, the injured worker complained of constant pain difficulty with range of motion maneuvers. She complained of constant pain in the bilateral shoulders, low back, bilateral hips, bilateral knees, bilateral ankles, feet, and toes. There was numbness in the ankles, feet, and toes. Per physical exam, the lumbar spine was tender to palpation to the bilateral L3-L4, and L4-L5, and L5-S1, bilateral sciatic notch and bilateral anterior thighs. The injured worker had pain with extension and flexion. Straight leg raising test was positive bilaterally. Decreased sensation was noted on the anterior aspect of the bilateral calves. Treatment to date has included physical therapy, chiropractic manipulation, injections, and medication management. The date of UR decision was 4/18/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Mobic 15mg #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67, 72.

Decision rationale: With regard to NSAIDs the MTUS Chronic Pain Medical Treatment Guidelines (CPMTG) states: "Low back pain (chronic): Both acetaminophen and NSAIDs have been recommended as first line therapy for low back pain. There is insufficient evidence to recommend one medication over the other. Selection should be made on a case-by-case basis based on weighing efficacy vs. side effect profile." I respectfully disagree with the UR physician. The MTUS does not mandate documentation of significant functional benefit for the continued use of NSAIDs. Meloxicam is indicated for the injured worker's low back pain. The request is medically necessary.

Relafen 500mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 72-73.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-68.

Decision rationale: With regard to the use of NSAIDs for chronic low back pain, the MTUS CPMTG states "Recommended as an option for short-term symptomatic relief. A Cochrane review of the literature on drug relief for low back pain (LBP) suggested that NSAIDs were no more effective than other drugs such as acetaminophen, narcotic analgesics, and muscle relaxants. The review also found that NSAIDs had more adverse effects than placebo and acetaminophen but fewer effects than muscle relaxants and narcotic analgesics. In addition, evidence from the review suggested that no one NSAID, including COX-2 inhibitors, was clearly more effective than another." The documentation indicates that the injured worker was concurrently treated with Mobic and there was no indication for an additional NSAID. Therefore, this request is not medically necessary.

Lidoderm patches 5% #60: Upheld

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

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

Decision rationale: The MTUS Chronic Pain Medical Treatment Guidelines page 112 states "Lidocaine Indication: Neuropathic pain Recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI antidepressants or an AED such as Gabapentin or Lyrica). Topical Lidocaine, in the formulation of a dermal patch (Lidoderm) has been designated for orphan status by the FDA for neuropathic pain. Lidoderm is also used off-label for diabetic neuropathy. No other commercially approved topical formulations of Lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. The medical records submitted for review do not indicate that there has been a trial of first-line therapy (tri-cyclic or SNRI antidepressants or an AED). There is also no diagnosis of diabetic

neuropathy or post-herpetic neuralgia. As such, Lidoderm is not recommended at this time. The request is not medically necessary.

Ultracet #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78-80. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, 04/10/14

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78, 93.

Decision rationale: Per MTUS Chronic Pain Medical Treatment Guidelines page 78 regarding on-going management of opioids "Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: Pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or nonadherent) drug related behaviors. These domains have been summarized as the 4 A's (Analgesia, activities of daily living, adverse side effects, and any aberrant drug-taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs." Review of the available medical records reveal no documentation to support the medical necessity of Ultracet nor is there any documentation addressing the '4 A's', which is a recommended practice for the on-going management of opioids. Specifically, the notes do not appropriately review and document pain relief, functional status improvement, appropriate medication use, or side effects. The MTUS considers this list of criteria for initiation and continuation of opioids in the context of efficacy required to substantiate medical necessity, and they do not appear to have been addressed by the treating physician in the documentation available for review. Furthermore, efforts to rule out aberrant behavior (e.g. [REDACTED] report, urine drug screen (UDS), opiate agreement) are necessary to assure safe usage and establish medical necessity. There is no documentation comprehensively addressing this concern in the records available for my review. As MTUS recommends discontinuing opioids if there is no overall improvement in function, this request is not medically necessary.

Skelaxin 800mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for pain) Page(s): 65.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Metaxalone (Skelaxin) Page(s): 61.

Decision rationale: Per MTUS Chronic Pain Medical Treatment Guidelines (CPMTG) page 61, Skelaxin is recommended with caution as a second-line option for short-term pain relief in patients with chronic LBP. With regard to muscle relaxants, the MTUS CPMTG page 63 states: "Recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP." The medical records submitted

for review indicate that the injured worker has been using this medication since at least 12/2013. As Skelaxin is not recommended for long-term use, and the most recent documentation did not contain documentation of muscle spasm, the request is not medically necessary.

Prilosec 20mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms and Cardiovascular Risk Page(s): 68-69.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms and Cardiovascular Risk Page(s): 68.

Decision rationale: In the treatment of dyspepsia secondary to NSAID therapy, the MTUS recommends stopping the NSAID, switching to a different NSAID, or considering the use of an H2-receptor antagonist or a PPI. The MTUS Chronic Pain Medical Treatment Guidelines recommend the use of proton pump inhibitors (PPI) in conjunction with NSAIDs in situations in which the patient is at risk for gastrointestinal events including: (1) age greater than 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID plus a low-dose ASA). CPMTG guidelines further specify: "Recommendations: Patients with no risk factor and no cardiovascular disease: Non-selective NSAIDs OK (e.g., ibuprofen, naproxen, etc.). Patients at intermediate risk for gastrointestinal events and no cardiovascular disease: (1) A non-selective NSAID with either a PPI (Proton Pump Inhibitor, for example, 20 mg Omeprazole daily) or Misoprostol (200 mg four times daily) or (2) a Cox-2 selective agent. Long-term PPI use (greater than 1 year) has been shown to increase the risk of hip fracture (adjusted odds ratio 1.44). Patients at high risk for gastrointestinal events with no cardiovascular disease: A Cox-2 selective agent plus a PPI if absolutely necessary. Patients at high risk of gastrointestinal events with cardiovascular disease: If GI risk is high the suggestion is for a low-dose Cox-2 plus low dose Aspirin (for cardio-protection) and a PPI. If cardiovascular risk is greater than GI risk the suggestion is Naproxyn plus low-dose aspirin plus a PPI. (Laine, 2006) (Scholmerich, 2006) (Nielsen, 2006) (Chan, 2004) (Gold, 2007) (Laine, 2007)". While it is noted that the injured worker is being treated with NSAIDs and had a history significant for gastroenteritis, there is no documentation of peptic ulcer, GI bleeding or perforation, or cardiovascular disease in the records available for my review. The injured worker's risk for gastrointestinal events is low, as such, this request is not medically necessary.