

<b>Case Number:</b>	CM14-0075148		
<b>Date Assigned:</b>	08/13/2014	<b>Date of Injury:</b>	03/26/2008
<b>Decision Date:</b>	10/16/2014	<b>UR Denial Date:</b>	04/25/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/22/2014

### 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 Physical Medicine and Rehabilitation, has a subspecialty in 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:

The records, presented for review, indicate that this 63-year-old male was reportedly injured on March 26, 2008. The most recent progress note, dated May 6 2014, indicated that there were ongoing complaints of low back and lower extremity pain. The physical examination demonstrated a 5'8", 258 pound individual with ongoing low back pain. There was tenderness to palpation of the lower lumbar musculoskeletal area. Numerous trigger points were outlined and a decrease in lumbar spine range of motion was noted. Motor function was noted to be 4/5 in the bilateral lower extremities. A decreased sensory evaluation was also noted. Diagnostic imaging studies objectified the surgical interventions and spinal cord stimulator. Previous treatment included multiple medications, acupuncture, physical therapy, lumbar fusion surgery and other pain management interventions. A request had been made for trigger point injections and medications and was not certified in the pre-authorization process on April 25, 2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Retrospective 4 Trigger Point Injections of 10cc of .25% bupivacaine (Date of Service: 04/08/14): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Trigger Point Injections.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Trigger Point Injections, Page(s): 122.

**Decision rationale:** As outlined in the MTUS, the criteria for the use of trigger point injections requires circumscribed trigger points with evidence upon palpation of a twitch response. The progress notes, presented for review, do not indicate such a response to physical examination. Furthermore, there is no objectification of stretching exercises, home-based physical therapy or other possible interventions. Therefore, based on the data presented, there is insufficient clinical information to establish the medical necessity of this procedure.

**Retrospective Zofran 4mg (Date of Service: 04/08/14)-unknown quantity:** 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)

**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, updated October 2014

**Decision rationale:** As outlined in the ODG (MTUS and ACOEM guidelines do not address), this medication is indicated for nausea and/or vomiting, chemotherapy, radiation treatment or postoperatively. None of these maladies exist. Furthermore, there is no notation of nausea or vomiting complaint. Therefore, there is insufficient clinical information to support the medical necessity of this medication.

**Retrospective Prevacid 30mg, #90 (Date of Service: 04/08/14):** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI Symptoms and Cardiovascular risk.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68-69.

**Decision rationale:** MTUS Guidelines recommend proton pump inhibitors for patients taking NSAIDs with documented GI distress symptoms, which are not documented in this patient. Therefore, based on the currently available information, the medical necessity for this GI protective medication has not been established in the records that were legible or understandable. Therefore, when noting the limited medications outlined, there is insufficient data presented to support this request.

**Retrospective AndroGel 1% daily (Date of Service: 04/08/14)-unknown dosage:** 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 Page(s): 110.

**Decision rationale:** As outlined in the MTUS, the limited circumstances for the application of this topical testosterone preparation would be objectification of hypogonadism secondary to the use of chronic opioid medication. There is no data presented to support that there are findings to suggest that this is necessary. Therefore, based on the medical records presented for review, this is not medically necessary.

**Retrospective Dendracin Topical Analgesic Cream (Date of Service: 04/08/14): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Capsaicin, topical.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 112.

**Decision rationale:** This is a topical preparation containing Methyl Salicylate 20.00%, Menthol 5.00%, and Capsaicin 0.0375%. The MTUS notes that topical analgesics are largely experimental and there have been few randomized controlled trials. Additionally, topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Based on the clinical documentation provided, there is no documentation that a previous trial of oral antidepressant or anticonvulsant has been attempted. As such, in accordance with the MTUS, the requested medication is not certified.

**Retrospective Sonata 10mg, #30 with 1 refill (Date of Service: 04/08/14): Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation The Official Disability Guidelines

**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, updated June 2014

**Decision rationale:** As outlined in the ODG (MTUS and ACOEM do not address), this a short acting non-benzodiazepine hypnotic indicated for short-term treatment of insomnia. There is a significant habit-forming side effect profile noted with this medication. Therefore, there is no clinical indication for chronic, long-term or indefinite use. Furthermore, the efficacy of this medication has not been described in the progress notes reviewed. As such, the medical necessity has not been established.

**Retrospective Neurontin 600mg with 1 refill (Date of Service: 04/08/14)-unknown quantity: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin (Neurontin).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 16-20, 49.

**Decision rationale:** The records, reviewed, noted that there were ongoing complaints of pain. However, the records do not support that there is any demonstrated efficacy or utility with the past use of this medication. Therefore, while noted to be a first-line treatment for neuropathic pain, the lack of objectification of any clinical success would not support the continued use of this medication.

**Retrospective Flexeril 7.5mg, #60 with 1 refill (Date of Service: 04/08/14): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (flexeril).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 41, 64.

**Decision rationale:** As outlined in the MTUS, there is support for use of this medication in the short-term to address chronic "flare-up" of muscle skeletal pain. The progress notes, presented for review, do not indicate this finding exists. Furthermore, there is no clinical indication for the chronic, indefinite or long-term use of this medication. So, this is not medically necessary.