

<b>Case Number:</b>	CM14-0084062		
<b>Date Assigned:</b>	08/08/2014	<b>Date of Injury:</b>	11/27/1993
<b>Decision Date:</b>	10/15/2014	<b>UR Denial Date:</b>	05/16/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/05/2014

### 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 and is licensed to practice in Nevada. 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 68-year-old female was reportedly injured on October 1, 1997. The mechanism of injury was not listed in the records reviewed. The most recent progress note, dated April 29, 2014, indicated that there were ongoing complaints of chronic low back pain. The physical examination demonstrated a normotensive (blood pressure reading 102/60) individual who weighed 189 pounds. There were low back and bilateral lower extremity pains. Muscle spasms noted in the low back and tenderness to palpation. It was noted as examination occurred in her wheelchair. Diagnostic imaging studies were not reviewed. Previous treatment included multiple surgeries, multiple medications and pain management interventions (pain pump). A request had been made for multiple medications, a reclining medical chair, and aqua/pool lift therapy 3 x weeks and was not certified in the pre-authorization process on May 16, 2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Neurontin 300mg #120:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs. Decision based on Non-MTUS Citation Official Disability Guidelines -pain chapter

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

**Decision rationale:** As outlined in the MTUS, Neurontin is a first-line treatment for neuropathic pain. The continued use is a function of documented efficacy. Based on the progress of reviewed, there is no noted efficacy as the pain complaints continued to be 8/10. As such, there is no medical necessity established for continued use of this medication.

**Lidoderm patch 5%:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines . page 56-57

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 56, 57, 112.

**Decision rationale:** As outlined in the MTUS, this medication is recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy. While noting that there are diffuse complaints of pain, a reflex sympathetic dystrophy, and lumbar facet disease and piriformis syndrome, there is no clinical indication presented that this topical preparation has ameliorated the symptomatology, increase functionality or allow for return to work. As such, there is no medical necessity for continued use of this medication, as there has not been any noted improvement.

**Nuvigil 150mg #30:** 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 updated July 2014

**Decision rationale:** This medication is not addressed in the MTUS or ACOEM guidelines. The parameters noted in the ODG were applied. As such, this medication is not recommended as this is a stimulant used to counteract the multiple analgesics. Given that this individual is taking several different benzodiazepine medications as well as narcotic opioid analgesics, reduction of those medications would obviate the need for this statement. The medical necessity is not established.

**Ambien 10mg #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 - pain chapter

**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 July, 2014

**Decision rationale:** This medication is not addressed in the MTUS or ACOEM guidelines. The parameters noted in the ODG were applied. This is a short acting, non-benzodiazepine hypnotic, which is approved for short-term intervention (2 to 6 weeks) and is not approved for long-term, chronic or indefinite use. When noting the multiple medications being employed and the side effect profiles outlined, there is no clear clinical indication for the continued use of this medication. The medical necessity has not been established.

**CMCT20 Td Creme, Capasaicin 0.0375%, Menthol 10%, Camphor 2.5%, Tramadol 20% creme 30mg:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 111.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26. MTUS (Effective July 18, 2009) Page(s): 112, 113.

**Decision rationale:** The use of topical analgesic is indicated if the patient will not respond or who is intolerant of other treatments. It is noted that there has been some difficulty achieving pain control. Based on the progress notes presented for review, there is no indication that this medication has achieved any of its intended effect. Therefore, when noting that these medications are "largely experimental," and that the combination of medications would be excluded, if any single preparation was not indicated (Tramadol), the continued use of this medication is not determined to be medically necessary.

**Reclining medical chair:** 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 Physical Medicine Page(s): 98. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Physical Medicine/Rehabilitation

**Decision rationale:** A reclining chair will not prevent lower back pain or discomfort. It is a personal comfort device and not medically necessary to treat the multiple pathologies identified. The injured worker has completed a program of land-based physical therapy and should be well versed in a self directed exercise home program to help control lower back pain.

**Aqua/pool lift therapy 3xweek:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines - low back chapter

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 22.

**Decision rationale:** Aquatic therapy is a recommended optional form of exercise therapy, where available as an alternative to land-based physical therapy. There is nothing in the progress notes indicating the land-based protocol could not be accomplished at this time. Furthermore, when noting the date of injury, and the multiple interventions completed, the transition to home exercise protocol is although be supported this time. Therefore, based on the clinical information presented for review, this is not medically necessary.

**Baclofen, 10mg #120:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants. Decision based on Non-MTUS Citation Official Disability Guidelines - pain chapter

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63, 64.

**Decision rationale:** The mechanism of action is blockade of the pre- and post-synaptic GABAB receptors. It is recommended orally for the treatment of spasticity and muscle spasm related to multiple sclerosis and spinal cord injuries. Neither is present in this case. It is noted there is a foot drop, and as such, there is no indication to treat spasticity. This is not medically necessary

**Vicodin 5mg #120:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-78, 88, 91.

**Decision rationale:** Norco (Hydrocodone/Acetaminophen) is a short acting opiate indicated for the management of moderate to severe breakthrough pain. The California MTUS guidelines support short-acting opiates at the lowest possible dose to improve pain and function, as well as the ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects. The injured employee has chronic pain; however, there is no objective clinical documentation of improvement in the pain or function or other parameters noting any success with the current regimen. As such, this request for Norco is not medically necessary.

**Xanax .25mg #60:** Upheld

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

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

**Decision rationale:** Not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. Their range of action includes sedative/hypnotic, anxiolytic, anticonvulsant, and muscle relaxant. Chronic benzodiazepines are the treatment of choice in very few conditions. Tolerance to hypnotic effects develops rapidly. Therefore, based on the lack of any noted significant improvement in the clinical situation this is not medically necessary.

**Cymbalta 30mg #30 with 5 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines antidepressants. Decision based on Non-MTUS Citation Official Disability Guidelines

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 43, 105.

**Decision rationale:** The MTUS guidelines support Cymbalta as a first-line treatment option for neuropathic pain, especially if tricyclic anti-depressants are ineffective, poorly tolerated or contraindicated. Review, of the available medical records, documents chronic pain. Treatment guidelines specifically state that Cymbalta should not be used in patients with hepatic insufficiency. When noting the multiple diagnoses noted, and that there is not a specific neuropathic pain disorder identified, there is insufficient clinical evidence to support the continued use of this medication. As such, this is not medically necessary.