MAXIMUS Federal Services

Case Number:	CM14-0098147		
Date Assigned:	08/11/2014	Date of Injury:	12/07/2001
Decision Date:	09/30/2014	UR Denial Date:	06/16/2014
Priority:	Standard	Application Received:	06/26/2014

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 Occupational 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:

This 54 year old patient had a date of injury on 12/7/2001. The mechanism of injury was not noted. In a progress noted dated 2/17/2014, subjective findings included low back pain, rated 7/10, radiation of the bilateral lower extremities and into feet, with associated numbness, tingling, and weakness. He also complains of constant bilateral hip, 7/10, and associated numbness and tingling. His low back has gotten worse since last visit. On a physical exam dated 2/17/2014, objective findings included lumbar spine range of motion is restricted, lower extremity motor strength weakness is noted in bilateral hip flexor and quadracepts muscle groups at 4/5, sensory examination is intact for all dermatomes. Diagnostic impression shows status post posterior spinal fusion at L2-L3 and L3-L4 with residual postoperative pain on 8/24/211, back pain, bilateral sacrolitis, osteoarthritis, bilateral knees, failed back surgery syndrome, and insomnia. Treatment to date includes medication therapy, and behavioral modification.

IMR ISSUES, DECISIONS AND RATIONALES

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

Prilosec 20mg #30: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 68. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) pain chapter.

Decision rationale: MTUS and the FDA support proton pump inhibitors in the treatment of patients with GI disorders such as gastric/duodenal ulcers, GERD, erosive esophagitis, or patients utilizing chronic NSAID therapy. Omeprazole is a proton pump inhibitor (PPI) used in treating reflux esophagitis and peptic ulcer disease. There is no comment that relates the need for the proton pump inhibitor for treating gastric symptoms associated with the medications used in treating this industrial injury. In general, the use of a PPI should be limited to the recognized indications and used at the lowest dose for the shortest possible amount of time. In a progress report dated 2/27/2014, the patient is diagnosed with gastritis. Therefore, the request for prilosec 20mg #30 is medically necessary.

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, Treatment Index, Zolpidem.

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, ambien.

Decision rationale: ODG and the FDA state that Ambien is approved for the short-term (usually two to six weeks) treatment of insomnia. Additionally, pain specialists rarely, if ever, recommend Ambien for long-term use. In the reports viewed, the patient is documented to be on Ambien since at least 2013, and guidelines only support short term use. Risk of dependency can develop with long term use. Therefore, the request for Ambien 10mg #30 is not medically necessary.

Percocet 10/325mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, long-term assessment.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78-81.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines do not support ongoing opioid treatment unless prescriptions are from a single practitioner and are taken as directed; are prescribed at the lowest possible dose; and unless there is ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. In the reports viewed, the patient has been on Percocet since at least 2012, with no documented functional improvement with the opioid regimen. In a progress report dated 2/17/2014, the patient still

complains of constant pain that has worsened since last visit. Therefore, the request for Percocet 10/325 #120 is not medically necessary.

Fentanyl Patches 100 mcg #10: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78-81.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines do not support ongoing opioid treatment unless prescriptions are from a single practitioner and are taken as directed; are prescribed at the lowest possible dose; and unless there is ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. In the reports viewed, the patient has been on Fentanyl since at least 2012, with no documented functional improvement with the opioid regimen. In a progress report dated 2/17/2014, the patient still complains of constant pain that has worsened since last visit. Therefore, the request for Fentanyl 100mcg/hr patches #10 is not medically necessary.

Senna Plus #120: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: FDA: Senna.

Decision rationale: The FDA states that Senna is indicated for short-term treatment of constipation; and preoperative and pre-radiographic bowel evacuation or for procedures involving GI tract. In the reports viewed, this patient has been on Senna since at least 2013, and due to the fact that the opioids are denied, there would be no rational justification for this patient to be on Senna Plus. Therefore, the request for Senna Plus #120 is not medically necessary.

Lyrica 200mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lyrica (pregabalin).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 20.

Decision rationale: MTUS states that Lyrica has been documented to be effective in treatment of diabetic neuropathy and postherpetic neuralgia, has FDA approval for both indications, and is considered first-line treatment for both. Peer-reviewed literature also establishes neuropathic

pain as an indication for Lyrica. In a progress report dated 2/17/2014, it was noted that this patient continued to have numbness and tingling, and reported pain worse from last visit. Furthermore, this patient is on Cymbalta for neuropathic pain. Therefore, the request for Lyrica 200mg #90 is not medically necessary.

Lidoderm 5%: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm (lidocaine patch).

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

Decision rationale: MTUS states that 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). ODG states that Lidoderm is not generally recommended for treatment of osteoarthritis or treatment of myofascial pain/trigger points. In a progress report dated 2/17/2014, there was no documented improvement noted with Lidoderm. Furthermore, this patient is also currently using Lyrica as well as Cymbalta to treat his neuropathic pain. Therefore, the request for Lidoderm 5% is not medically necessary.

Flurbiprofen 20% cream 120 gm: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines state that ketoprofen, lidocaine (in creams, lotion or gels), capsaicin in anything greater than a 0.025% formulation, baclofen, Boswellia Serrata Resin, and other muscle relaxants, and gabapentin and other antiepilepsy drugs are not recommended for topical applications. In addition, any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. In the reports viewed, there was no discussion of failure of 1st line oral analgesics to justify the use of this topical, which is not recommended. Therefore, the request for Flurbiprofen 20% cream #120 is not medically necessary.

Ketoprofen / Ketamine 20/10% cream 120gm: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines state that ketoprofen, lidocaine (in creams, lotion or gels), capsaicin in anything greater than a 0.025% formulation, baclofen, Boswellia Serrata Resin, and other muscle relaxants, and gabapentin and other antiepilepsy drugs are not recommended for topical applications. In addition, any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. In the reports viewed, there was no discussion of failure of 1st line oral analgesics to justify the use of this topical, which is not recommended. Therefore, the request for Ketoprofen/ketamine 20/10% Cream #120 is not medically necessary.

Gabapentin / Cyclobenzaprine / Capsaicin 10/10/0.0375% cream 120gm: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines state that ketoprofen, lidocaine (in creams, lotion or gels), capsaicin in anything greater than a 0.025% formulation, baclofen, Boswellia Serrata Resin, and other muscle relaxants, and gabapentin and other antiepilepsy drugs are not recommended for topical applications. In addition, any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. In the reports viewed, there was no discussion of failure of 1st line oral analgesics to justify the use of this topical, which is not recommended. Therefore, the request for Gabapentin/cyclobenzaprine/capsaicin 10/10/.375% cream #120 is not medically necessary.