

Case Number:	CM14-0190277		
Date Assigned:	11/21/2014	Date of Injury:	03/18/1998
Decision Date:	01/14/2015	UR Denial Date:	10/16/2014
Priority:	Standard	Application Received:	11/14/2014

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 Family Medicine and is licensed to practice in North Carolina. 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 patient has a reported date of injury of 03/18/1998. The mechanism of injury occurred when the patient was trying to break apart a fight between two students and noted a pop in her back. The patient has the diagnoses of lumbar disc disease, lumbar spondylolisthesis, depression, lumbar pain and lumbar strain/sprain. Per the progress notes provided for review from the primary treating physician dated 10/01/2014, the patient had complaints of ongoing low back pain. Previous treatment modalities have included physical therapy, lumbar epidural injections, bilateral laminectomy and facetectomy at L4/5 with posteriolateral and transverse process fusion, and interbody fusion and SCS implant. The physical exam noted decreased lumbar range of motion, lumbar paraspinal tenderness and spasm and decreased sensation in the L5-S1 dermatome bilaterally. Treatment plan recommendations included transforaminal steroid injection at left L4/5 and L5/S1 and continuation of medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

One lumbar transforaminal epidural steroid injection (ESI) at left L4-L5 and L5-S1:

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 Epidural Steroid Injections Page(s): 46.

Decision rationale: The California chronic pain medical treatment guidelines section on epidural steroid injections (ESI) states: "Criteria for the use of Epidural steroid injections: Note: The purpose of ESI is to reduce pain and inflammation, restoring range of motion and thereby facilitating progress in more active treatment programs, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit. 1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 2) Initially unresponsive to conservative treatment (exercises, physical methods, non-steroidal anti-inflammatory drugs (NSAIDs) and muscle relaxants). 3) Injections should be performed using fluoroscopy (live x-ray) for guidance. 4) If used for diagnostic purposes, a maximum of two injections should be performed. A second block is not recommended if there is inadequate response to the first block. Diagnostic blocks should be at an interval of at least one to two weeks between injections. 5) No more than two nerve root levels should be injected using transforaminal blocks. 6) No more than one interlaminar level should be injected at one session. 7) In the therapeutic phase, repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year. (Manchikanti, 2003) (CMS, 2004) (Boswell, 2007) 8) Current research does not support a "series-of-three" injection in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections." This patient does have a diagnosis of lumbar degenerative disc disease and documented trail of physical therapy. However, the only objective findings on the physical exam are decreased sensation in the L5/S1 dermatome and no signs of radiculopathy on the physical exam. For these reasons, the criteria set forth above have not been met; therefore this request is not medically necessary.

Soma 350 mg, 120 count: 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 Muscle Relaxants Page(s): 63-65.

Decision rationale: The California chronic pain medical treatment guidelines section on muscle relaxants 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. (Chou, 2007) (Mens, 2005) (Van Tulder, 1998) (Van Tulder, 2003) (Van Tulder, 2006) (Schnitzer, 2004) (See, 2008) Muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in most low back pain (LBP) cases, they show no benefit beyond non-steroidal anti-inflammatory drugs (NSAIDs) in pain and overall improvement. Also there is no additional benefit shown in combination with NSAIDs. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. (Homik, 2004) Carisoprodol (Soma, Soprodon 350, Vanadom, generic available): Neither of these formulations is recommended for longer than a 2 to 3 week period. The long term chronic use of this

medication is not recommended per the California MTUS. The medication has not been prescribed for the acute flare up of chronic low back pain. The specific use of this medication for greater than 3 weeks is not recommended per the California MTUS. The criteria set forth above for its use has not been met; therefore, this request is not medically necessary..

Neurontin 600 mg, sixty count: 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 Neurontin Page(s): 18.

Decision rationale: The California chronic pain medical treatment guidelines section on Gabapentin states: Gabapentin (Neurontin , Gabarone, generic available) has been shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia, and has been considered as a first-line treatment for neuropathic pain. (Backonja, 2002) (ICSI, 2007) (Knotkova, 2007) (Eisenberg, 2007) (Attal, 2006) This RCT concluded that gabapentin monotherapy appears to be efficacious for the treatment of pain and sleep interference associated with diabetic peripheral neuropathy, and exhibits positive effects on mood and quality of life. (Backonja, 1998) It has been given Food and Drug Administration (FDA) approval for treatment of post-herpetic neuralgia. The number needed to treat (NNT) for overall neuropathic pain is 4. It has a more favorable side-effect profile than Carbamazepine, with a number needed to harm of 2.5. (Wiffen2-Cochrane, 2005) (Zaremba, 2006) Gabapentin in combination with morphine has been studied for treatment of diabetic neuropathy and postherpetic neuralgia. When used in combination the maximum tolerated dosage of both drugs was lower than when each was used as a single agent and better analgesia occurred at lower doses of each. (Gilron-NEJM, 2005) Recommendations involving combination therapy require further study. This medication is indicated for neuropathic pain as a first line agent. However there neither is no mention of a neuropathic pain diagnosis nor is there evidence of neurologic insult on the listed exam besides decreased sensation. In the absence of such diagnosis, this request is not medically necessary.

Flurbi (NAP) cream, 180 grams: 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 Topical Analgesics Page(s): 111-113.

Decision rationale: The California chronic pain medical treatment guidelines section on topical analgesics states: Recommended as an option as indicated below. Largely experimental in use with few randomized controlled trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. (Namaka, 2004) These agents are applied locally to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. (Colombo, 2006) Many

agents are compounded as monotherapy or in combination for pain control (including non-steroidal anti-inflammatory drugs (NSAIDs), opioids, capsaicin, local anesthetics, antidepressants, glutamate receptor antagonists, α -adrenergic receptor agonist, adenosine, cannabinoids, cholinergic receptor agonists, β -agonists, prostanoids, bradykinin, adenosine triphosphate, biogenic amines, and nerve growth factor). (Argoff, 2006) There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Non-steroidal anti-inflammatory agents (NSAIDs): The efficacy in clinical trials for this treatment modality has been inconsistent and most studies are small and of short duration. Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but either not afterward, or with a diminishing effect over another 2-week period. (Lin, 2004) (Bjordal, 2007) (Mason, 2004) When investigated specifically for osteoarthritis of the knee, topical NSAIDs have been shown to be superior to placebo for 4 to 12 weeks. In this study the effect appeared to diminish over time and it was stated that further research was required to determine if results were similar for all preparations. (Biswal, 2006) These medications may be useful for chronic musculoskeletal pain, but there are no long-term studies of their effectiveness or safety. (Mason, 2004) Indications: Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment: Recommended for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. Neuropathic pain: Not recommended as there is no evidence to support use. In this case, this medication has been used for greater than the 4 recommended per the California MTUS. In addition, the topical NSAID prescribed is not listed as a recommended topical NSAID, per the California MTUS. Also the use of topical NSAID on the spine is not a recommended. Therefore, this request is not medically necessary.