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| Case Number: | CM14-0190649 | | |
| Date Assigned: | 11/24/2014 | Date of Injury: | 02/15/2008 |
| Decision Date: | 01/09/2015 | UR Denial Date: | 10/24/2014 |
| 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 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 is a 57 year old female who sustained an injury on 02/15/2008. The current diagnoses include low back pain with radicular pain into the right leg, greater than left, right knee medial and lateral meniscus tear seen on MRI, status post meniscectomy and chondroplasty, bilateral plantar fasciitis, right Achilles tendonitis and chronic pain syndrome. Per the doctor's note dated 11/03/2014, she had complaints of low back pain, right knee pain and right ankle pain. Physical examination revealed tenderness across the lumbar paraspinal muscles, pain with facet loading, pain along facet L3 through S1 more so on the left side, pain with extension, no more than 15 degrees, positive straight leg raise on the right at 70 degrees and negative on the left, some swelling across the knee joint more medially than laterally; positive McMurray's medially and negative laterally. The medications list includes Cozaar, Norvasc, Colace, Tramadol, Atenolol, Gabapentin, Flexeril, Percocet, Atrovent, Albuterol and QVAR. Her surgical history includes gall bladder removal, hysterectomy, right knee surgery and right ankle surgery. She has had lumbar spine MRI dated 1/24/12 which revealed lumbar degenerative disc disease, lumbar facet joint arthropathy and central disc bulge at L4-L5; right and left knee MRI and ankle MRI which revealed plantar fasciitis. She has had physical therapy visits and epidural steroid injections for this injury.

IMR ISSUES, DECISIONS AND RATIONALES

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

Percocet 5/325mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 91.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for Use Page(s): 75-80.

Decision rationale: This is a request for Percocet, which is an opioid analgesic. It contains Acetaminophen and Oxycodone. According to CA MTUS guidelines cited above, "A therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Before initiating therapy, the patient should set goals, and the continued use of opioids should be contingent on meeting these goals." The records provided do not specify that that patient has set goals regarding the use of opioid analgesic. A treatment failure with non-opioid analgesics is not specified in the records provided. Other criteria for ongoing management of opioids are: "The lowest possible dose should be prescribed to improve pain and function; continuing review of overall situation with regard to non-opioid means of pain control. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. To aid in pain and functioning assessment, the patient should be requested to keep a pain diary that includes entries such as pain triggers, and incidence of end-of-dose pain. It should be emphasized that using this diary will help in tailoring the opioid dose. Consider the use of a urine drug screen to assess for the use or the presence of illegal drugs." The continued review of overall situation with regard to non-opioid means of pain control is not documented in the records provided. The response to non-opioid analgesic for this patient is not specified in the records provided. The records provided do not provide a documentation of response in regards to pain control and functional improvement to opioid analgesic for this patient. A recent urine drug screen report is not specified in the records provided. With this, it is deemed that this patient does not meet criteria for the ongoing use of opioids analgesics. The medical necessity of Percocet 5/325mg #60 is not established for this patient at this time.

Lidoderm 5% #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, Lidoderm (Lidocaine patch) Page(s): 111-113, 56-57.

Decision rationale: According to the MTUS Chronic Pain Guidelines regarding topical analgesics state that the use of topical analgesics is "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. There is little to no research to support the use of many of these agents." According to the MTUS Chronic Pain Guidelines "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). This is not a first-line treatment and is only FDA approved for post-herpetic neuralgia." MTUS guidelines recommend topical analgesics for neuropathic pain only when trials of antidepressants and anticonvulsants have failed to relieve symptoms. Response and

failure of antidepressants and anticonvulsants for these symptoms are not specified in the records provided. Intolerance of oral medications is not specified in the records provided. Any evidence of post-herpetic neuralgia is not specified in the records provided. The medical necessity of Lidoderm 5% #60 is not fully established for this patient.

Flexeril 7.5mg #60: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril, Amrix, Fexmid, Generic Available) Page(s): 64.

Decision rationale: Cyclobenzaprine is a skeletal muscle relaxant and a central nervous system (CNS) depressant. According to California MTUS, Chronic pain medical treatment guidelines, Cyclobenzaprine is "Recommended for a short course of therapy. Cyclobenzaprine is more effective than placebo in the management of back pain. It has a central mechanism of action, but it is not effective in treating spasticity from cerebral palsy or spinal cord disease." According to the records provided patient had complaints of low back, with tenderness. On examination, there was tenderness across the lumbar paraspinal muscles, pain with facet loading. According to the cited guidelines Flexeril is recommended for short term therapy and not recommended for longer than 2-3 weeks. Short term or prn use of Cyclobenzaprine in this patient for acute exacerbations would be considered reasonable appropriate and necessary. The request for Flexeril 7.5mg #60 is medically appropriate to use as prn during acute exacerbations.