MAXIMUS Federal Services

Case Number:	CM14-0195618		
Date Assigned:	12/03/2014	Date of Injury:	01/08/2003
Decision Date:	01/15/2015	UR Denial Date:	11/19/2014
Priority:	Standard	Application Received:	11/21/2014

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 Anesthesiology, has a subspecialty in Pain Management 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:

According to the records made available for review, this is a 54-year-old female with a 1/8/03 date of injury. At the time (11/18/14) of the Decision for Topamax 25mg #30, Fentanyl 12mcg/hr #10, Trigger point injection of 4cc of Lidocaine and 1cc of Methylprednisolon, and Perocet 10/325mg #90, there is documentation of subjective (debilitating back pain with radiation to the coccyx region, left hand pain, and right arm pain radiating to the thumb) and objective (moderate tenderness to palpation over the cervical spine with referred pain to the bilateral shoulders, decreased sensation on the right lateral arm and thumb, and trigger points and taut band of muscles causing referred pain into the right side of the lumbar spine) findings, current diagnoses (chronic low back pain, cervical degenerative disc disease, lumbar facet arthropathy, lumbosacral neuritis, and status post L4-L5 spinal fusion), and treatment to date (Trigger point injections and medications (including ongoing treatment with Perocet and Fentanyl Patch since at least 7/15/14)). Medical reports identify that the patient had approximately 2 weeks of pain relief due to trigger point injections on 7/28/14 and 9/10/14; and a signed Opioid agreement. Regarding Topamax 25mg #30, there is no documentation that a trial of other anticonvulsants has failed. Regarding Fentanyl 12mcg/hr #10, there is no documentation of persistent, moderate to severe chronic pain that requires continuous, around-the-clock opioid administration for an extended period of time, and cannot be managed by other means; and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of Fentanyl patch to date. Regarding Trigger point injection of 4cc of Lidocaine and 1cc of Methylprednisolone, there is no documentation of greater than 50% pain relief obtained for six weeks after an injection and documented evidence of functional improvement. Regarding Perocet 10/325mg #90, there is no documentation of

functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Perocet use to date.

IMR ISSUES, DECISIONS AND RATIONALES

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

Topamax 25mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs) Page(s): 16-21.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topiramate (Topamax) Page(s): 21.

Decision rationale: Chronic Pain Medical Treatment Guidelines identifies documentation of neuropathic pain when other anticonvulsants have failed, as criteria necessary to support the medical necessity of Topiramate. Within the medical information available for review, there is documentation of diagnoses of chronic low back pain, cervical degenerative disc disease, lumbar facet arthropathy, lumbosacral neuritis, and status post L4-L5 spinal fusion. In addition, there is documentation of neuropathic pain. However, there is no documentation that a trial of other anticonvulsants has failed. Therefore, based on guidelines and a review of the evidence, the request for Topamax 25mg #30 is not medically necessary.

Fentanyl 12mcg/hr #10: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Duragesic (fentanyl transdermal system) Page(s): 44. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Duragesic and Fentanyl Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20; and FDA

Decision rationale: Chronic Pain Medical Treatment Guidelines identifies documentation of chronic pain in patients who require continuous opioid analgesia for pain that cannot be managed by other means, as criteria necessary to support the medical necessity of Duragesic. California MTUS Chronic Pain Medical Treatment Guidelines identifies that Duragesic in not recommended as first-line therapy. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. ODG identifies documentation that Duragesic is not for use in routine musculoskeletal pain. FDA identifies documentation of persistent, moderate to severe chronic pain that requires continuous, around-the-clock opioid administration for an extended period of time, and cannot be managed by other means; that the patient is already receiving opioid therapy, has demonstrated opioid tolerance, and requires a total daily dose at least equivalent to Duragesic25 mcg/h; and no contraindications exist, as criteria necessary to support the medical

necessity of Duragesic patch. Within the medical information available for review, there is documentation of diagnoses of chronic low back pain, cervical degenerative disc disease, lumbar facet arthropathy, lumbosacral neuritis, and status post L4-L5 spinal fusion. In addition, there is documentation of moderate chronic and pain that Fentanyl patch is not used as first-line therapy and the patient is already receiving opioid therapy. However, there is no documentation of pain that requires continuous, around-the-clock opioid administration for an extended period of time, and cannot be managed by other means; that the patient has demonstrated opioid tolerance, and requires a total daily dose at least equivalent to Duragesic25 mcg/h; and no contraindications exist. In addition, given documentation of ongoing treatment with Fentanyl patches, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Fentanyl patch to date. Therefore, based on guidelines and a review of the evidence, the request for Fentanyl 12mcg/hr #10 is not medically necessary.

Trigger point injection of 4cc of Lidocaine and 1cc of Methylprednisolone: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Trigger Point Injections Page(s): 122.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Trigger point injections Page(s): 122.

Decision rationale: Chronic Pain Medical Treatment Guidelines identifies documentation of myofascial pain syndrome; circumscribed trigger points with evidence upon palpation of a twitch response as well as referred pain; symptoms have persisted for more than three months; medical management therapies such as ongoing stretching exercises, physical therapy, NSAIDs and muscle relaxants have failed to control pain; radiculopathy is not present (by exam, imaging, or neuro-testing); and no more than 3-4 injections per session, as criteria necessary to support the medical necessity of trigger point injections. Additionally California MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of greater than 50% pain relief is obtained for six weeks after an injection, documented evidence of functional improvement, and injections not at an interval less than two months, as criteria necessary to support the medical necessity of repeat trigger point injections. Within the medical information available for review, there is documentation of diagnoses of chronic low back pain, cervical degenerative disc disease, lumbar facet arthropathy, lumbosacral neuritis, and status post L4-L5 spinal fusion. In addition, there is documentation of previous trigger point injections and at an interval less than two months. However, despite documentation that the patient had approximately 2 weeks of pain relief due to trigger point injections on 7/28/14 and 9/10/14, there is no (clear) documentation of greater than 50% pain relief is obtained for six weeks after an injection and documented evidence of functional improvement. Therefore, based on guidelines and a review of the evidence, the request for Trigger point injection of 4cc of Lidocaine and 1cc of Methylprednisolone is not medically necessary.

Perocet 10/325mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-80. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

Decision rationale: Chronic Pain Medical Treatment Guidelines necessitate documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects, as criteria necessary to support the medical necessity of opioids. California MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of chronic low back pain, cervical degenerative disc disease, lumbar facet arthropathy, lumbosacral neuritis, and status post L4-L5 spinal fusion. In addition, given documentation of a signed Opioid agreement, there is documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. However, given documentation of ongoing treatment with Perocet, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Perocet use to date. Therefore, based on guidelines and a review of the evidence, the request for Perocet 10/325mg #90 is not medically necessary.