MAXIMUS Federal Services

Case Number:	CM14-0197744		
Date Assigned:	12/08/2014	Date of Injury:	05/31/2003
Decision Date:	01/20/2015	UR Denial Date:	10/29/2014
Priority:	Standard	Application Received:	11/25/2014

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 Internal 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:

The patient had his injury on 5/31/13. In the past, he was on Nucynta and Opana ER but had been titrated off this medication. On 10/24/14, he saw his pain medicine physician who noted that he had lumbar pain radiating to both legs and neck pain radiating to the right arm. He was noted to have hypersensitivity to light touch on this arm also. He noted that cervical MRI showed disc disease and osteophytes. He was also noted to have both insomnia and depression secondary to the chronic pain. However, both Elavil and Neurontin helped to ameliorate this. The M.D. noted that he had somatic neuropathic pain from the disc bulging and that stellate blocking had helped him in the past. However, at present he was noted to have had an exacerbation of the pain and that decrease in pain meds caused an increase in severe pain symptomatology. His diagnoses were: discogenic cervical and lumbar pain, lumbar nerve root pain, Reflex Sympathetic Dystrophy, OSA, ankle sprain, and depression secondary to pain. Recommended treatment was Elavil, Cymbalta, Norco, Neurontin, Ultram, and Naprosyn 15% cream because the patient had gastritis and could not tolerate the oral medicine. The M.D. noted that at this point the patient had declined to have surgery because of the fear of invasive procedures. However, the UR denied these medications as well as cervical ESI.

IMR ISSUES, DECISIONS AND RATIONALES

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

Naprosyn 15 percent transdermal compound cream: Overturned

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 21, 22,Chronic Pain Treatment Guidelines Page(s): 112.

Decision rationale: The FDA does not currently recommend the use of Ketoprofen in a topical application. It has a very high incidence of inducing photosensitivity dermatitis, and the absorption of the drug depends on the base in which it is delivered. Topical treatment can result in blood accumulations and systemic side effects similar to oral injection of the same medication. Patients with renal disease or other systemic diseases should use this medication with caution. The MTUS noted that Flector patches or Diclofenac topical gel in 1 study was found effective and well tolerated in a select group of acute sprain and tendinitis patients. Also, another study that was termed intermediate quality found that the gel was effective in patients with shoulder periarthritis and lateral epicondylitis and that this study provided further evidence on the use of topical NSAIDs as optimal approved treatment of localized musculoskeletal disorders. However, Up to date does state that the gel may increase the risk of the patient having an MI, CVA, or GI bleed. In the above patient, we have chronic pain which is difficult to treat. He is intolerant of oral NSAID's secondary to gastritis but has tolerated Naprosyn as a topical application. No other side effects such as phototoxicity or organ pathology have been documented. The MD states that this medicine has helped control his pain and therefore should be prescribed. This request is medically necessary.

Norco 10/325 mg #120: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 75, 91.

Decision rationale: Norco is noted to be a short acting opioid effective in controlling chronic pain and often used intermittently and for breakthrough pain. It is noted that it is used for moderate to moderately severe pain. The dose is limited by the Tylenol component and officially should not exceed 4 grams per day of this medicine. The most feared side effects are circulatory and respiratory depression. The most common side effects include dizziness, sedation, nausea, sweating, dry mouth, and itching.In general, opioid effectiveness is noted to be augmented with 1- education as to its benefits and limitations, 2- the employment of non-opioid treatments such as relaxation techniques and mindfulness techniques, 3- the establishment of realistic goals, and 4- encouragement of self-regulation to avoid the misuse of the medication. The MTUS notes that opioid medicines should be not the first line treatment for neuropathic pain because of the need for higher doses in this type of pain. It is also recommended that dosing in excess of the equivalent of 120 mg QD of morphine sulfate should be avoided unless there are unusual circumstances and pain management consultation has been made. It is also stated that the use of opioids in chronic back pain is effective in short term relief of pain and that long term relief of pain appears to be limited. However, the MTUS does state that these meds should be continued if

the patient was noted to return to work and if there was noted to be an improvement in pain and functionality. Also, it is noted that if the medicine is effective in maintenance treatment that dose reduction should not be done.This medicine has been noted to be effective in pain control by the MD. No sign of side effects or abuse has been noted and the patient has been weaned off of Opana. The patient appears compliant and should be allowed to continue use of this medicine. Therefore, this request is medically necessary.

Ultram 50 mg #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): 29, 77, 94.

Decision rationale: The chronic pain section of the MTUS notes that Ultram or Tramadol is a central acting analgesic and has opioid activity and inhibits reuptake of serotonin and norepinephrine and is reported to be effective in neuropathic pain and its side effects are similar to traditional opioids. The MTUS also states that it should not be given with Soma because of the combination causing euphoria and sedation. It also states that prior to starting it other traditional pain meds should be tried such as NSAID's and that opioids are not a first line treatment for pain. It also notes the patient should be screened for possible abuse potential and other traits that would make a patient unreliable such as depression. In this patient, we already have the use of one short acting opioid, Norco. We should not combine 2 different short acting opioids and complicate the treatment. Therefore, it is more beneficial to be titrating one opioid medicine. Therefore, this request is not medically necessary.

Neurontin 300 mg #120: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 16,17, 18.

Decision rationale: Neurontin is used mainly to treat neuropathic pain and especially for the treatment of post herpetic neuropathy. The MTUS states that Neurontin is an anticonvulsant and it reduces hypersensitivity, specifically allodynia and hyper algesia. It also is effective for treatment of anxiety and is an aid to sleep. It is described as a first line treatment of neuropathic pain, which is most commonly caused by D.M. It has also been found beneficial to treat post - stroke pain and managing fibromyalgia pain and lumbar stenosis pain. However, it has not been found beneficial for myofascial pain or axial low back pain. Lastly, there is insufficient evidence to recommend it for combined treatment with morphine for DM neuropathic pain.The above patient has radicular pain caused by nerve root irritation and it is controversial as to whether or not such agents as Neurontin can be beneficial in treating this pain. However, the MD has noted

benefit from this medicine and no side effects have occurred. Therefore, the Neurontin should be allowed. This request is medically necessary.

Elavil 25 mg #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 (ODG)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 13, 14, 15.

Decision rationale: Elavil or Amitriptyline is a tricyclic antidepressant which is a first line agent for treatment of chronic pain unless it is found to be ineffective, is poorly tolerated, or is contraindicated. It has been found to be effective in the treatment of fibromyalgia.In general, tricyclics are recommended over SSRI's for treatment of chronic pain. Caution must be exercised because of the risk of toxicity and overdose which is a significant risk of death due to cardiac and neurological effects. They are considered as a first line treatment for neuropathic pain and they work equally effective in both depressed and non-depressed patients. Trials have shown their effectiveness in central post stroke pain, post herpetic neuralgia, both diabetes and non-diabetes neuropathic pain. However, recent trials have not shown effectiveness in spinal cord pain and phantom limb pain. Tricyclic are contraindicated in cardiac conduction or decompensation problems. They can cause both cardiac conduction block and arrhythmia in patients greater than 40 years old. A screening EKG should be done. Other side effects include seizure, dry mouth, sweating, dizziness, orthostatic hypotension, fatigue, constipation, and urine retention.
When Elavil is used for neuropathic pain 10 to 25 mg should generally be the starting dose and this can be titrated up to 100 mg if needed. Again, for fibromyalgia the starting dose is often 10 to 25 mg and the studies that have been done have utilized a dose of 25 to 50 mg. The lowest effective dose should always be utilized.In the above patient, we already have one medicine for neuropathic pain, Neurontin. It has not yet been titrated to its maximum dose. It would be appropriate to first titrate it to its maximal dose before adding another drug to treat neuropathic pain. Therefore, this request is not medically necessary.

Cymbalta 30 mg #30 with 5 refills: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 15,16,44.

Decision rationale: Cymbalta is noted to be an SNRI antidepressant medication by the MTUS. It is FDA approved for treatment of depression, anxiety, diabetic neuropathy, and fibromyalgia. It is used off label for other neuropathic pain and radiculopathy. However, it is a first line option for diabetic neuropathy.There is no high quality evidence to use it for lumbar radiculopathy. More studies are needed in order to determine efficacy for treating other types of neuropathic pain. It has been noted to decrease pain in both patients who are depressed and in patients who

are not depressed. However, it appears more efficacious in patients with comorbid depression. Its side effects include dizziness, fatigue, somnolence, drowsiness, anxiety, insomnia, nausea, emesis, andweight loss. Also, it has been shown to increase the risk of further liver damage in patients with preexisting liver pathology. Therefore, it should be used with caution in patients who abuse alcohol. Lastly, it has been noted to worsen diabetic control and can be associated with sexual dysfunction.Cymbalta is dosed at 60 mg one a day off label for chronic pain but is usually dosed from 20 to 60 mg qd. In fibromyalgia patients 60 mg twice a day may be beneficial. It is generally regarded to have a more benign side effect profile than tricyclic medication.The above patient has depression caused by his chronic pain. Part of the treatment for chronic pain is to treat the concomitant depression. Therefore, this request is medically necessary.

Cervical epidural steroid injection: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injection.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 174. Decision based on Non-MTUS Citation Up to date Topic 5263 and Version 14.0

Decision rationale: The ACOEM notes that epidural injection of steroids is an optional treatment with neck radiculopathy in order to avoid surgery. It also states that there is no evidence that invasive procedures such as needle acupuncture, injection of trigger points, or facet joint injections are beneficial in treating acute neck pain. It also states that there is no evidence that the injection of steroids, lidocaine, or opioids into the epidural space is of any benefit in acute pain. However, it does state that some pain specialists believe that either diagnostic or therapeutic injection of such medicines into the epidural space may be of benefit in the transitional phase between acute and chronic pain. Up to date states that there are small prospective and retrospective studies suggesting that epidural steroid injection into the neck has proved successful in 40 to 60 % of patients. However, it is difficult to know whether the improvement is from the injection or the natural course of the disease. The review goes on to say that epidural steroid injections into the cervical region is recommended in severe pain after 6 to 8 weeks of conservative therapy have been attempted unsuccessfully in order to avoid surgery. It notes that adverse effects of this procedure are rare if done in specialty centers with experience in this procedure. In the above patient, there is chronic radicular cervical pain which has been exacerbated. This patient could be a surgical candidate except he does not want this type of invasive procedure. He is on multiple pain medication for treatment and a successful procedure would be beneficial in decreasing his dependence on medication. Therefore, the cervical epidural injection is medically necessary.