MAXIMUS Federal Services

Case Number:	CM15-0103869		
Date Assigned:	06/10/2015	Date of Injury:	07/02/2013
Decision Date:	07/15/2015	UR Denial Date:	04/24/2015
Priority:	Standard	Application Received:	05/29/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: New York
Certification(s)/Specialty: Internal Medicine

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 injured worker is a 55 year old male, who sustained an industrial injury on 7/2/13. He reported pain in his lower back and left knee. The injured worker was diagnosed as having lumbar disc degeneration with myelopathy, lumbosacral sprain and left knee sprain. Treatment to date has included chiropractic treatments, oral and topical medications. As of the PR2 dated 4/7/15, the injured worker reports 7/10 pain in the lower back and left knee. Objective findings include decreased lumbar and left knee range of motion. There are only three progress notes submitted for review and part of the text is difficult to read. The treating physician requested Gabapentin 10%, Amitriptyline 10%, Bupivacaine 5% in a cream base, Flurbiprofen 20%, Baclofen 10%, Dextromethorphan 2% in a cream base, Terocin patch #30, acupuncture x 12 sessions to the left knee, chiropractic x 12 treatments to the left knee, an EMG/NCV of the bilateral lower extremities, Anaprox DS 550mg #60, Prilosec DR 20mg #60, Norco 10/325mg #60, Soma 350mg #90 and a lumbar epidural injection at L3-S1 x 3.

IMR ISSUES, DECISIONS AND RATIONALES

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

Gabapentin 10%, Amitriptyline 10%, Bupivacaine 5% in a cream base: Upheld

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

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

Decision rationale: According to the California MTUS Guidelines (2009), topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied topically to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control including, for example, NSAIDs, opioids, capsaicin, muscle relaxants, local anesthetics or antidepressants. Guidelines indicate that any compounded product that contains at least 1 non-recommended drug (or drug class) is not recommended for use. In this injured worker the Medical necessity for the requested topical compound cream has not been established. There is no documentation in the submitted Medical Records that the injured worker has failed a trail of antidepressants and anticonvulsants. Therefore, as per guidelines stated above, the requested topical compound cream is not medically necessary.

Flurbiprofen 20%, Baclofen 10%, Dextromethorphan 2% in a cream base: Upheld

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

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

Decision rationale: According to the California MTUS Guidelines (2009), topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied topically to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control including, for example, NSAIDs, opioids, capsaicin, muscle relaxants, local anesthetics or antidepressants. In this case, there is no documentation provided necessitating Flurbiprofen 20%, Baclofen 10%, Dextromethorphan 2% in a cream base. There is no documentation that injured worker has intolerance to other previous medications. Therefore, as per guidelines stated above, the requested topical compound cream is not medically necessary.

Terocin patch #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transdermal formulation Page(s): 112.

Decision rationale: According to the California MTUS Guidelines (2009), transdermal analgesics, such as the Lidocaine patches, are primarily recommended for neuropathic pain when trials of anti-depressants and anti-convulsants have failed. Transdermal analgesics are systemic agents entering the body through a transdermal means. Many agents are compounded as monotherapy or in combination for pain control, for example, NSAIDs, opioids, or antidepressants. Terocin patch either contains Lidocaine alone or in combination with Menthol. Transdermal Terocin may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tricyclic or SNRI anti-depressants, or an AED, such as gabapentin or Lyrica). In addition, this medication is not generally recommended for treatment of osteoarthritis or treatment of myofascial pain/trigger points. In this case, the request of Terocin patch for the injured worker is not medically necessary and has not been established.

Twelve acupuncture visits for the left knee, twice a week for six weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints, Acupuncture Treatment Guidelines, Chronic Pain Treatment Guidelines Acupuncture Medical Treatment Guidelines (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 13 Pages 8 & 9.

Decision rationale: The California MTUS/ACOEM Guidelines state that Acupuncture is used as an option when pain medication is reduced or not tolerated, it may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. It is the insertion and removal of filiform needles to stimulate acupoints (acupuncture points). Needles may be inserted, manipulated, and retained for a period of time. Acupuncture can be used to reduce pain, reduce inflammation, increase blood flow, increase range of motion, decrease the side effect of medication-induced nausea, promote relaxation in an anxious patient, and reduce muscle spasm. There is no documentation that in this injured worker, pain medication is reduced or not tolerated. Therefore, as per guidelines stated above, the requested treatment is not medically necessary.

Twelve chiropractic care visits for the left knee, twice a week for six weeks: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Procedure Summary – Pain Chiropractic treatment.

Decision rationale: Official Disability Guidelines do not recommended knee manipulation. Manipulation is manual therapy that moves a joint beyond the physiologic range-of-motion but not beyond the anatomic range-of-motion. There are no studies showing that manipulation is

proven effective for patients with knee and leg complaints. The request for twelve chiropractic care visits for the left knee, twice a week for six weeks is not medically necessary.

EMG/NCV of the bilateral lower extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Procedure Summary.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287 to 326.

Decision rationale: The California MTUS/ACOEM Guidelines state that electromyography (EMG) and nerve conduction velocities (NCV), including H-reflex tests, may help identify subtle, focal neurologic dysfunction in patients with low back symptoms, lasting more than 3 to 4 weeks. The ODG further states that NCVs are recommended if the EMG is not clearly radiculopathy or clearly negative, or to differentiate radiculopathy from other neuropathies or non-neuropathic processes if other diagnoses may be likely based on the clinical exam. There is minimal justification for performing NCVs when a patient is already presumed to have symptoms on the basis of radiculopathy. The submitted Medical Records of this injured worker do not reveal any documentation of clinically obvious radiculopathy or focal neuro-deficits. Requested Treatment EMG/NCV of the bilateral lower extremities is not medically necessary.

Anaprox DS/Naproxen 550mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 66, 73.

Decision rationale: Anaprox DS/Naproxen 550mg is a non-steroidal anti-inflammatory medication (NSAID). This type of medication is recommended for the treatment of chronic pain as a second line of therapy after acetaminophen. The documentation indicates the injured worker has been maintained on long-term NSAID therapy and there has been no compelling evidence presented by the provider to document that the patient has had any significant improvements from this medication. Medical necessity for the requested treatment has not been established. The requested treatment is not medically necessary.

Prilosec/Omeprazole DR 20mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Proton Pump Inhibitor Page(s): 68.

Decision rationale: According to the California MTUS (2009), Omeprazole (Prilosec), is proton pump inhibitor (PPI) that is recommended for patients taking NSAIDs, with documented GI distress symptoms, or at risk for gastrointestinal events. GI risk factors include: age >65, history of peptic ulcer, GI bleeding, or perforation; concurrent use of aspirin, corticosteroids, and/or anticoagulants, or high dose/multiple NSAIDs. PPIs are highly effective for their approved indications, including preventing gastric ulcers induced by NSAIDs. There is no documentation indicating that this patient had any GI symptoms or risk factors. The medical necessity for Omeprazole has not been established. The requested medication is not medically necessary.

Norco/Hydrocodone 10/325mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 72 to 97.

Decision rationale: The injured worker is complaining of persistent lumbosacral and left knee pain. Medical documentation is not clear about the (1) least reported pain over the period since last assessment; (2) average pain (3) intensity of pain after taking the opioid (4) how long it takes for pain relief (5) how long pain relief lasts (6) improvement in pain (7) improvement in function. These are necessary to meet MTUS guidelines. MTUS discourages long term usage unless there is evidence of ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. This request is not medically necessary.

Soma/Carisoprodol 350mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Procedure Summary.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 29, 63.

Decision rationale: The CA MTUS does not recommend muscle relaxants for chronic pain. Non-sedating muscle relaxants are an option for short term exacerbations of chronic low back pain. Soma (Carisoprodol) is the muscle relaxant requested in this case. This medication is sedating. No reports show any specific and significant improvements in pain or function as a result of prescribing muscle relaxants. According to the MTUS guidelines, Soma is categorically not recommended for chronic pain, noting its habituating and abuse potential. Review of submitted Medical Records do not establish the necessity of the requested medication for the injured worker. Therefore the request is not medically necessary.

Lumbar epidural injection L3-S1 times three: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs) Page(s): 46.

Decision rationale: The California MTUS Guidelines state that 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. It further states the following: 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, 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 no more than 2 ESI injections. There is no documentation of corroboration of radiculopathy either by imaging studies or by clinical information. Therefore, the request is not medically necessary.