

Case Number:	CM15-0104148		
Date Assigned:	06/11/2015	Date of Injury:	10/13/2008
Decision Date:	09/29/2015	UR Denial Date:	04/29/2015
Priority:	Standard	Application Received:	06/01/2015

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: California

Certification(s)/Specialty: Preventive Medicine, Occupational 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 50 year old female with an industrial injury dated 10/13/2008. The injured worker's diagnoses include lumbar myoligamentous injury with associated facet arthropathy, bilateral lower extremity radiculopathy, medication induced gastritis, bilateral knee internal derangement, status post arthroscopic surgery of right knee on 03/08/2012, status post arthroscopic surgery of left knee on 09/19/2013, status post posterior lumbar interbody fusion, L3-S1 on 09/25/2012, removal of hardware on 12/11/2014, reactionary depression/anxiety, and Arachnoiditis. Treatment consisted of Magnetic Resonance Imaging (MRI) of bilateral knee/lumbar spine, Computed tomography scan of lumbar spine, Electromyography (EMG) of the lower extremities, prescribed medications, and periodic follow up visits. In a progress note dated 04/17/2015, the injured worker presented for follow up evaluation for the bilateral knee and low back. The injured worker reported improvement from recent Synvisc injection to left knee on 3/17/2015 and right knee on 2/13/2015. The injured worker continued to complain of low back pain with improvement following removal of retained metal in lumbar spine on 12/11/2014. Objective findings revealed obvious distress, antalgic gait favoring the right lower extremity, bilateral lumbar musculature tenderness to palpitation with muscle rigidity, trigger points, decrease lumbar range of motion, facet loading along lumbar spine, positive bilateral straight leg raises, and decreased sensation along the L5-S1 distribution bilaterally. Bilateral knee exam revealed tenderness to palpitation along the medial lateral joint line with mild soft tissue swelling and crepitus with general range of motion, right greater than left. The treating physician prescribed services for lumbar spinal cord stimulator trial, replacement of batteries and electrodes for transcutaneous electrical nerve stimulation (TENS) unit, Prozac 20mg #60, Norco 10/325mg #90, FexMid 7.5mg (short term use) #60, Ultracet 37.5/325mg #60, Prilosec 20mg #60, Doral 50mg #30, and LidoPro Topical Cream now under review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar Spinal Cord Stimulator Trial: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Spinal Cord Stimulators (SCS) Page(s): 105-106.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Spinal cord stimulators (SCS) Page(s): 105-107.

Decision rationale: According to MTUS, indications for spinal cord stimulator are failed back syndrome, complex regional pain syndrome, post amputation pain, postherpetic neuralgia, spinal cord injury, pain associated with multiple sclerosis, and peripheral vascular disease. In addition, psychological screening should be obtained prior to a spinal cord stimulator trial, especially for serious conditions such as severe depression or schizophrenia. There is no documentation that the patient meets the criteria for a lumbar spinal cord stimulator trial. Lumbar Spinal Cord Stimulator Trial is not medically necessary.

Replacement of Batteries and Electrodes for TENS Unit: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy Page(s): 114-116.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrical nerve stimulation (TENS) Page(s): 113-117.

Decision rationale: The MTUS does not recommend a TENS unit as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration. Patient has reported significant functional improvement with previous TENS unit use. There is documentation that the patient meets the criteria necessary for replacement of batteries and electrodes for TENS Unit. I am reversing the previous utilization review decision. Replacement of Batteries and Electrodes for TENS Unit is medically necessary.

Prozac 20mg, 1-2 BID PRN, #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines SSRIs (selective serotonin reuptake inhibitors) Page(s): 107.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), SSRIs (selective serotonin reuptake inhibitors).

Decision rationale: According to the Official Disability Guidelines SSRIs are not recommended as a treatment for chronic pain, but SSRIs may have a role in treating secondary depression. It has been suggested that the main role of SSRIs may be in addressing psychological symptoms associated with chronic pain. More information is needed regarding the role of SSRIs and pain. SSRIs have not been shown to be effective for low back pain. Prozac 20mg, 1-2 BID PRN, #60 is not medically necessary.

Norco 10/325mg, 1 tablet TID, #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Weaning of Medications Page(s): 78-80, 91, 124.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-94.

Decision rationale: The Chronic Pain Medical Treatment Guidelines state that continued or long-term use of opioids should be based on documented pain relief and functional improvement or improved quality of life. Despite the long-term use of Norco, the patient has reported very little, if any, functional improvement or pain relief over the course of the last 6 months. Norco 10/325mg, 1 tablet TID, #90 is not medically necessary.

FexMid 7.5mg (short term use) #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine Page(s): 64.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 64.

Decision rationale: The MTUS Chronic Pain Treatment Guidelines do not recommend long-term use of muscle relaxants such as Cyclobenzaprine. The patient has been taking Cyclobenzaprine for an extended period, long past the 2-3 weeks recommended by the MTUS. The clinical information submitted for review fails to meet the evidence based guidelines for the requested service. FexMid 7.5mg (short term use) #60 is not medically necessary.

Ultracet 37.5/325mg, 1 BID, #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Weaning of Medications Page(s): 78-80, 124. Decision based on Non-MTUS Citation ODG Pain, Opioids, specific drug list.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for chronic pain Page(s): 60.

Decision rationale: According to the MTUS in regard to medications for chronic pain, only one medication should be given at a time, and interventions that are active and passive should remain unchanged at the time of the medication change. A trial should be given for each individual medication. A record of pain and function with the medication should be recorded. According to this citation from the MTUS, medications should not be initiated in a group fashion, and specific benefit with respect to pain and function should be documented for each medication. There is no documentation of the above criteria for either of the narcotics that the patient has been taking. Ultracet 37.5/325mg, 1 BID, #60 is not medically necessary.

Prilosec 20mg, 1 BID PRN, #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI symptoms and cardiovascular risk Page(s): 68-69.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68.

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines, prior to starting the patient on a proton pump inhibitor, physicians are asked to evaluate the patient and to determine if the patient is at risk for gastrointestinal events. Criteria used are: (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID. There is no documentation that the patient has any of the risk factors needed to recommend the proton pump inhibitor Prilosec. Prilosec 20mg, 1 BID PRN, #60 is not medically necessary.

Doral 50mg per orem QHS, #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

Decision rationale: The MTUS states that benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. Their range of action includes sedative/hypnotic, anxiolytic, anticonvulsant, and muscle relaxant. Chronic benzodiazepines are the treatment of choice in very few conditions. Tolerance to hypnotic effects develops rapidly. Tolerance to anxiolytic effects occurs within months and long-term use may actually increase anxiety. Doral 50mg per orem QHS, #30 is not medically necessary.

LidoPro Topical Cream: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 104, 111-112.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112.

Decision rationale: Lidopro lotion is a compounded medication which contains the following: Lidocaine 4.5%, Methyl Salicylate 27.5%, Menthol 10%, Capsaicin 0.0325%. It is classified by the FDA as a topical analgesic. There is little to no research to support the use of many Compounded Topical Analgesics. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. According to the Chronic Pain Medical Treatment Guidelines, compounds containing Lidocaine are not recommended for non-neuropathic pain. There is only one trial that tested 4% Lidocaine for treatment of chronic muscle pain. The results showed there was no superiority over placebo. LidoPro Topical Cream is not medically necessary.