

Case Number:	CM15-0135204		
Date Assigned:	07/23/2015	Date of Injury:	05/23/2001
Decision Date:	09/22/2015	UR Denial Date:	06/17/2015
Priority:	Standard	Application Received:	07/13/2015

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: Physical Medicine & Rehabilitation

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 was a 68 year old male, who sustained an industrial injury, May 23, 2001. The injured worker previously received the following treatments Cyclobenzaprine, Norco, Topamax, Motrin, Cymbalta, Quinine, left knee injections and left knee brace. The injured worker was diagnosed with status post left knee surgery now has occasional swelling and persistent pain, lumbosacral radiculopathy in the right and left L5-S1 levels, chronic musculoskeletal spasm in the lumbosacral paraspinal muscles, peripheral neuropathy, cramping in the lower extremities and cervical spasms. According to progress note of May 7, 2015, the injured worker's chief complaint was left knee pain. The injured worker was unable to sit or stand for long periods of time. The left knee pain was rated at 8 out of 10. The injured rated the lower back pain at 6 out of 10 with numbness and tingling in the feet. The bilateral arm pain was 7 out of 10. The pain made it difficult to hold a cane for ambulation. The Norco, Topamax, Flexeril and Cymbalta everyday managed the injured worker's pain to allow activities of daily living a little bit more comfortably. The physical exam noted the strength of the lower extremities to be 4 out of 5. The straight leg raises were positive at 25 degrees on the left. The sensory exam noted diminished sensation to pinprick in both the upper and lower extremities. The treatment plan included prescriptions for Flexeril, Topamax and Norco one occipital injection and one trigger point injection.

IMR ISSUES, DECISIONS AND RATIONALES

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

Flexeril 10mg #90 with three refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 63-66.

Decision rationale: The patient presents on 05/07/15 with left knee pain rated 8/10, lower back pain rated 6/10 with associated numbness/tingling in the bilateral feet, and bilateral arm pain rated 7/10. The patient's date of injury is 05/23/01. Patient is status post partial medial and lateral meniscectomies in the left knee. The request is for flexeril 10mg #90 with three refills. The RFA is dated 05/28/15. Physical examination dated 05/07/15 reveals occipital trigger points bilaterally, severe trapezius spasms bilaterally, positive Tinel's sign in the bilateral wrists and elbows, absent ankle reflexes bilaterally, and decreased sensation to pinprick in the upper and lower extremities bilaterally. The patient is currently prescribed Norco, Topamax, Motrin, Cymbalta, and Flexeril. Diagnostic imaging was not included. Patient's current work status is not provided. MTUS Chronic Pain Medical Treatment Guidelines, page 63-66 under Muscle relaxants states: "Recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP. The most commonly prescribed antispasmodic agents are carisoprodol, cyclobenzaprine, metaxalone, and methocarbamol, but despite their popularity, skeletal muscle relaxants should not be the primary drug class of choice for musculoskeletal conditions." In regard to the request for Flexeril, the provider has specified an excessive duration of therapy. This patient has been prescribed Flexeril since at least 07/21/11. Guidelines indicate that muscle relaxants such as Cyclobenzaprine are considered appropriate for acute exacerbations of lower back or cervical pain. However, MTUS Guidelines do not recommend use for longer than 2 to 3 weeks, the requested 90 tablets in addition to prior use does not imply the intent to limit use of this medication to 2-3 weeks. Therefore, the request is not medically necessary.

Norco 10mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for chronic pain criteria for use of opioids Page(s): 60, 61, 76-78, 88, 89.

Decision rationale: The patient presents on 05/07/15 with left knee pain rated 8/10, lower back pain rated 6/10 with associated numbness/tingling in the bilateral feet, and bilateral arm pain rated 7/10. The patient's date of injury is 05/23/01. Patient is status post partial medial and lateral meniscectomies in the left knee. The request is for Norco 10MG #90. The RFA is dated 05/28/15. Physical examination dated 05/07/15 reveals occipital trigger points bilaterally, severe trapezius spasms bilaterally, positive Tinel's sign in the bilateral wrists and elbows, absent ankle

reflexes bilaterally, and decreased sensation to pinprick in the upper and lower extremities bilaterally. The patient is currently prescribed Norco, Topamax, Motrin, Cymbalta, and Flexeril. Diagnostic imaging was not included. Patient's current work status is not provided. MTUS Guidelines pages 88 and 89 under Criteria for Use of Opioids (Long-Term Users of Opioids): "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 under Criteria For Use of Opioids - Therapeutic Trial of Opioids, also requires documentation of the 4As -analgesia, ADLs, adverse side effects, and adverse behavior-, as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. In regard to the continuation of Norco for the management of this patient's chronic pain, the treater has not provided adequate documentation of efficacy to continue its use. Addressing medication efficacy, progress note dated 05/07/15 has the following: "As long as he takes Norco, Topamax, Flexeril, Cymbalta every day, his pain is manageable and he is able to get to his activities of daily living a little more comfortably." Such vague documentation does not satisfy MTUS guidelines, which require documentation via a validated scale, activity-specific functional improvements, consistent urine drug screening, and a stated lack of aberrant behavior. In this case, the provider has documented prior consistency with medications and does not note any aberrant behaviors. However, the treater does not provide specific functional improvements or a measure of analgesia via a validated scale. Without such documentation, continuation of this medication cannot be substantiated. Owing to a lack of complete 4A's documentation, the request is not medically necessary.

Topamax 200mg #60 with three refills: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topiramate (Topamax) Antiepileptic drugs for chronic pain Page(s): 21, 16, 17.

Decision rationale: The patient presents on 05/07/15 with left knee pain rated 8/10, lower back pain rated 6/10 with associated numbness/tingling in the bilateral feet, and bilateral arm pain rated 7/10. The patient's date of injury is 05/23/01. Patient is status post partial medial and lateral meniscectomies in the left knee. The request is for Topamax 200mg #60 with three refills. The RFA is dated 05/28/15. Physical examination dated 05/07/15 reveals occipital trigger points bilaterally, severe trapzeius spasms bilaterally, positive Tinel's sign in the bilateral wrists and elbows, absent ankle reflexes bilaterally, and decreased sensation to pinprick in the upper and lower extremities bilaterally. The patient is currently prescribed Norco, Topamax, Motrin, Cymbalta, and Flexeril. Diagnostic imaging was not included. Patient's current work status is not provided. Regarding Topiramate (Topamax), MTUS Guidelines page 21 states "Topiramate has been shown to have variable efficacy, with failure to demonstrate efficacy in neuropathic pain of 'central' etiology. It is still considered for use for neuropathic pain when other anticonvulsants have failed". MTUS Guidelines page 16 and 17 regarding antiepileptic drugs for chronic pain also states "that there is a lack of expert consensus on the treatment of neuropathic pain in general due to heterogeneous etiologies, symptoms, physical signs, and mechanisms. Most

randomized controlled trials for the use of this class of medication for neuropathic pain had been directed at postherpetic neuralgia and painful polyneuropathy". In regard to the continuation of Topamax for this patient's lower back pain with a neuropathic component, the request is appropriate. Addressing medication efficacy, progress note dated 05/07/15 has the following: "As long as he takes Norco, Topamax, Flexeril, Cymbalta every day, his pain is manageable and he is able to get to his activities of daily living a little more comfortably." Given this patient's diagnosis of peripheral neuropathy, as well as analgesia and functional improvements attributed to medications, the continuation of this medication is substantiated. The request is medically necessary.

One occipital injection: 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) Neck and Upper back chapter, under Diagnostic Occipital Nerve Blocks.

Decision rationale: The patient presents on 05/07/15 with left knee pain rated 8/10, lower back pain rated 6/10 with associated numbness/tingling in the bilateral feet, and bilateral arm pain rated 7/10. The patient's date of injury is 05/23/01. Patient is status post partial medial and lateral meniscectomies in the left knee. The request is for one occipital injection. The RFA is dated 05/28/15. Physical examination dated 05/07/15 reveals occipital trigger points bilaterally, severe trapezius spasms bilaterally, positive Tinel's sign in the bilateral wrists and elbows, absent ankle reflexes bilaterally, and decreased sensation to pinprick in the upper and lower extremities bilaterally. The patient is currently prescribed Norco, Topamax, Motrin, Cymbalta, and Flexeril. Diagnostic imaging was not included. Patient's current work status is not provided. ODG Neck and Upper back chapter, under Diagnostic Occipital Nerve Blocks states: "Under Study. Greater occipital nerve blocks -GONB- have been recommended by several organizations for the diagnosis of both occipital neuralgia and cervicogenic headaches. It has been noted that both the International Association for the Study of Pain and World Cervicogenic Headache Society focused on relief of pain by analgesic injection into cervical structures, but there was little to no consensus as to what injection technique should be utilized and lack of convincing clinical trials to aid in this diagnostic methodology. Difficulty arises in that occipital nerve blocks are non-specific. This may result in misidentification of the occipital nerve as the pain generator. In addition, there is no research evaluating the block as a diagnostic tool under controlled conditions: placebo, sham, or other control an additional problem is that patients with both tension headaches and migraine headaches respond to GONB. In one study comparing patients with cervicogenic headache to patients with tension headaches and migraines, pain relief was found by all three categories of patients. Due to the differential response, it has been suggested that GONB may be useful as a diagnostic aid in differentiating between these three headache conditions." In this case, the provider appears to be requesting an occipital nerve block. Addressing the criteria for occipital nerve blocks, there is no evidence of subjective complaints or physical examination findings suggestive of cervicogenic headaches or occipital neuralgia, only evidence of persistent cervical spasms. Owing to a lack of subjective complaints appropriate for considering occipital nerve blocks as a diagnostic measure, and the

lack of firm guideline support for such procedures as therapeutic interventions, the request cannot be substantiated. Therefore, the request is not medically necessary.

One trigger point injection: 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) Pain chapter, under Trigger Point Injections.

Decision rationale: The patient presents on 05/07/15 with left knee pain rated 8/10, lower back pain rated 6/10 with associated numbness/tingling in the bilateral feet, and bilateral arm pain rated 7/10. The patient's date of injury is 05/23/01. Patient is status post partial medial and lateral meniscectomies in the left knee. The request is for one trigger point injection. The RFA is dated 05/28/15. Physical examination dated 05/07/15 reveals occipital trigger points bilaterally, severe trapezius spasms bilaterally, positive Tinel's sign in the bilateral wrists and elbows, absent ankle reflexes bilaterally, and decreased sensation to pinprick in the upper and lower extremities bilaterally. The patient is currently prescribed Norco, Topamax, Motrin, Cymbalta, and Flexeril. Diagnostic imaging was not included. Patient's current work status is not provided. ODG Pain chapter, under Trigger Point Injections, has the following: "Recommended for myofascial pain syndrome as indicated below, with limited lasting value. The advantage appears to be in enabling patients to undergo remedial exercise therapy more quickly. The primary goal of trigger point therapy is the short-term relief of pain and tightness of the involved muscles in order to facilitate participation in an active rehabilitation program and restoration of functional capacity. TPIs are generally considered an adjunct rather than a primary form of treatment and should not be offered as either a primary or a sole treatment modality. Criteria for the use of TPIs: TPIs with a local anesthetic may be recommended for the treatment of myofascial pain syndrome when all of the following criteria are met: 1. Documentation of circumscribed trigger points with evidence upon palpation of a twitch response as well as referred pain; 2. Symptoms have persisted for more than three months..." In regard to the request for cervical trigger point injections, guideline criteria for such injections have not been satisfied. Progress note dated 05/07/15 notes palpable trigger points in the occipital region, though does not indicate the presence of taut bands or referred pain. ODG requires documentation of circumscribed trigger points with evidence of twitch response and referred pain prior to considering trigger point injections. In this case, the physical examination findings fail to satisfy these requirements. Therefore, the request is not medically necessary.