

Case Number:	CM15-0161101		
Date Assigned:	09/03/2015	Date of Injury:	04/23/1996
Decision Date:	10/27/2015	UR Denial Date:	08/04/2015
Priority:	Standard	Application Received:	08/17/2015

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: Anesthesiology

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 who sustained an industrial injury on 4-23-96. She had complaints of right knee pain. Treatments include: medications, physical therapy, injections and surgery. Progress report dated 7-8-15 reports continued complaints of constant pain and discomfort in the upper, mid and lower back and bilateral knees. The pain radiates to bilateral legs and feet. She has poor balance and weakness. The pain has worsened and she has chronic migraine headaches. Botox injection helped to reduce headaches. The pain level was reduced by 60-70% after the rhizotomy on 11-11-14. Diagnoses include: chronic migraine headaches, lumbar spine sprain and strain syndrome, lumbar radiculopathy, failed back surgery syndrome and bilateral knee joint arthropathy. Plan of care includes: medications refilled Norco, Percocet, soma, Maxalt, trazadone, Lidoderm patch and Xanax, recommend lumbar rhizotomy-piriformis, request Botox injection for migraine and follow up in 4-6 weeks. Work status: permanently 100% disabled.

IMR ISSUES, DECISIONS AND RATIONALES

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

Follow-up visit: Overturned

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004.

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

Decision rationale: According to the ODG, the need for an office visit is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability and reasonable physician judgment and is also based on what medications the patient is taking. The documentation indicates that this patient has an established relationship with the provider and regular office visits are necessary to evaluate her status, her medical regimen, and plans for further treatment. Medical necessity for the requested service is established. The requested service is medically necessary.

Lumbar rhizotomy/piriformis: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Facet Rhizotomy.

Decision rationale: According to the ODG, the criteria for the use of therapeutic medial branch blocks are as follows: 1) no more than one therapeutic intra-articular block is recommended. 2) There should be no evidence of radicular pain, spinal stenosis, or previous fusion. 3) If successful (initial pain relief of 70%, plus pain relief of at least 50% for a duration of 6 weeks) the recommendation is to proceed with a diagnostic medial branch block and subsequent neurotomy (if the medial branch block (MMB) is positive). 4) No more than 2 joint levels may be blocked at any one time. In this case, the patient has had a previous fusion at L4-L5/L5-S1. which do not meet ODG recommendations for facet joint blocks or to be followed by facet joint rhizotomy. Medical necessity for the requested service has not been established. Therefore, the requested service is not medically necessary.

Botox injections for migraine headaches: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Botulinum toxin (Botox Myobloc). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Botulinum toxin (Botox).

Decision rationale: According to the CA MTUS and ODG guidelines, Botulinum toxin (Botox) is not recommended for most chronic pain disorders. It is not recommended for "tension-type headache, migraine headache, fibromyositis, chronic neck pain, myofascial pain syndrome and trigger point injections." It is recommended for cervical dystonia, urinary incontinence following spinal cord injury, spasticity following traumatic brain injury, and for prevention of headache in patients with chronic migraines. A chronic migraine is defined as having a history of

migraine and experiencing a headache on most days of the month. Criteria for Botox for prevention of chronic migraine headaches include: An initial 12-week trial if all of the following are met: (1) Diagnosed with chronic migraine headache; (2) More than 15 days per month with headaches lasting 4 hours a day or longer; (3) Not responded to at least three prior first-line migraine headache prophylaxis medications, choose from: Amitriptyline, beta blockers (Metoprolol, Propranolol, and Timolol), Topiramate as well as valproic acid and its derivatives, are first-line agents for the treatment of chronic migraines. In addition, continuing treatment for ongoing prevention include: frequency reduced by at least 7 days per month (when compared to pre-treatment average); or duration was reduced by at least 100 hours per month (compared to pre-treatment). Botox discontinuation if headache days reduced to less than 15 days a month over three consecutive months (qualifies as episodic migraine, not covered for Botox). In this case, there is no documentation that all criteria above have been met. Medical necessity for Botox has not been established. The requested injections for migraine headaches are not medically necessary.

Percocet 5/325mg #15: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Opioids.

Decision rationale: According to the CA MTUS and the ODG, Percocet (Oxycodone/Acetaminophen) is a short-acting opioid analgesic indicated for moderate to severe pain, and is used to manage both acute and chronic pain. The treatment of chronic pain with any opioid analgesic requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. A pain assessment should include current pain, intensity of pain after taking the opiate, and the duration of pain relief. In this case, there is no documentation of the onset of analgesia or duration of pain relief. In addition, there is no documentation of change in the patient's functional capabilities from visit to visit. Medical necessity of the requested medication has not been established. Of note, discontinuation of an opioid analgesic should include a taper, to avoid withdrawal symptoms. The requested treatment with Percocet 10/325 mg is not medically necessary.

Norco 7.5/325mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Opioids.

Decision rationale: According to the CA MTUS and ODG, Norco 7.5/325mg (Hydrocodone/Acetaminophen) is a short-acting opioid analgesic indicated for moderate to moderately severe pain, and is used to manage both acute and chronic pain. The treatment of chronic pain with any opioid analgesic requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. A pain assessment should include current pain, intensity of

pain after taking the opiate, and the duration of pain relief. In this case, there is insufficient evidence that the opioids were prescribed according to the CA MTUS guidelines, which recommend prescribing according to function, with specific functional goals, return to work, random drug testing, an opioid contract, and documentation of a prior failure of non-opioid therapy. There is no documentation of significant pain relief or increased function from the opioids used to date. Medical necessity of the requested medication has not been established. Of note, discontinuation of an opioid analgesic should include a taper to avoid withdrawal symptoms. The requested medication is not medically necessary.

Soma 350mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Carisoprodol (Soma).

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. Medical necessity for the requested medication has not been established. The requested medication is not medically necessary.

Trazodone 50mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Trazadone.

Decision rationale: According to the ODG, Trazodone (Desyrel) is a sedative hypnotic. It is not recommended for long-term use but is recommended for short-term use. It is discouraged in the chronic phase of injury and pain. "They can be habit-forming, and they may impair function and memory more than opioid pain relievers. There is also concern that they may increase pain and depression over the long-term. In this study, receiving hypnotic prescriptions was associated with greater than a threefold increased hazard of death even when prescribed less than 18 pills/year." In this case, there is no documentation indicating that this medication has been proven to be beneficial for the treatment of the patient's condition. Medical necessity for the requested medication has not been established. The requested medication is not medically necessary.

Lidoderm patch 5% #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Lidoderm (lidocaine patch), Topical Analgesics.

Decision rationale: Lidoderm 5% Patches: According to the California MTUS Guidelines (2009), topical analgesics, such as the Lidoderm 5% patch, 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, for example, NSAIDs, opioids, or antidepressants. Lidoderm is the brand name for a lidocaine patch. Topical lidocaine may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants, or an AED, such as gabapentin or Lyrica). Lidoderm patches are not a first-line treatment and are only FDA approved for post-herpetic neuralgia. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than post-herpetic neuralgia. In this case, medical necessity of the requested medication has not been established. The requested topical analgesic is not medically necessary.

Xanax 0.5mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Benzodiazepines.

Decision rationale: According to CA MTUS Guidelines, benzodiazepines are not recommended for long-term use for the treatment of chronic pain because long-term efficacy is unproven and there is a risk of dependency. Xanax (Alprazolam) is a short-acting benzodiazepine, having anxiolytic, sedative, and hypnotic properties. Most guidelines limit use of this medication to four weeks. The documentation indicates the patient has depression and anxiety. The guidelines recommend that a more appropriate treatment for an anxiety and depression disorder would be an antidepressant. There is no documentation provided indicating that the patient is maintained on any antidepressant medication. The patient would benefit from a mental health evaluation to determine the appropriate medical therapy for her depression and anxiety conditions. Medical necessity for the requested medication has not been established. The requested medication is not medically necessary.