

Case Number:	CM15-0035173		
Date Assigned:	03/03/2015	Date of Injury:	09/16/2013
Decision Date:	04/20/2015	UR Denial Date:	02/12/2015
Priority:	Standard	Application Received:	02/24/2015

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 (IW) is a 32 year old female who sustained an industrial injury on 09/16/2013. She has reported constant low back pain with radicular symptoms. Diagnoses include lumbar spine disc protrusions at L3-4(broad based), L4-5 (broad based) and L5-S1 per MRI 12/28/2013, lumbar spine prolonged right H-reflex which suggests a proximal lesion and possibly a subtle right S1 radiculopathy (per EMG/NCV of 06/09/2014, lumbar spine sprain/strain, lumbar spine stenosis (per MRI 12/28/2013), lumbar spine with facet joint arthropathy at right L5-S1, lumbar spine with right sided radiculopathy, and obesity. Treatments to date include medications and epidural steroid injections. A progress note from the treating provider dated 01/14/2015 indicates that there is spasm in the bilateral paraspinous musculature at L3-S1. Tenderness was noted upon palpation bilaterally at the L3-S1 paravertebral area. The range of motion was slightly to moderately limited. Flexion and extension significantly increased the pain. Sensory exam shows decreased sensitivity to touch along the L4 dermatome in the right lower extremity. Motor exam showed decreased strength of the extensor muscles along the L3-5 dermatome in the right lower extremity. Seated straight leg raise was positive on the right for radicular pain at 60 degrees. Treatments include an epidural steroid injection at bilateral L5-S1 on 12/10/2014 that provided 50-80 percent overall improvements. Treatment plans include medications. On 02/12/2015 Utilization Review non-certified a request for Celebrex 200mg #30. The MTUS Guidelines were cited. On 02/12/2015 Utilization Review non-certified a request for Omeprazole 20mg #60. The MTUS Guidelines were cited. On 02/12/2015 Utilization Review non-certified a request for Lidoderm 5% #30. The MTUS

Guidelines were cited. On 02/12/2015 Utilization Review non-certified a request for Robaxin 500mg #60. The MTUS Guidelines were cited. On 02/12/2015 Utilization Review non-certified a request for Tramadol 50mg #90. The MTUS Guidelines were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lidoderm 5% #30: 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): 56-57.

Decision rationale: 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, the claimant complains of constant low back pain and there is no documentation of objective functional improvement with the medication. Medical necessity for the requested medication is not established. The requested medication is not medically necessary.

Tramadol 50mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for the treatment of chronic pain Page(s): 91-97.

Decision rationale: According to the California MTUS, Tramadol (Ultram) is a synthetic opioid which affects the central nervous system and is indicated for the treatment of moderate to severe pain. Per CA MTUS Guidelines, certain criteria need to be followed, including an ongoing review and documentation of pain relief and functional status, appropriate medication use, and side effects. Pain assessment should include current pain: last reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid, and the duration of pain relief. According to the medical records, there has been no documentation of the medication's analgesic effectiveness, functional improvement, and no clear documentation that the patient has

responded to ongoing opioid therapy. Medical necessity of the requested medication has not been established. Of note, discontinuation of an opioid analgesic requires a taper to avoid withdrawal symptoms. Medical necessity for the requested medication is not established. The requested medication is not medically necessary.

Omeprazole 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 inhibitors Page(s): 68. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Proton Pump Inhibitors.

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. In this case, the patient reported medication-associated gastrointestinal upset, but the requested NSAID was not certified. The medical necessity for Omeprazole has not been established. The requested medication is not medically necessary.

Celebrex 200mg #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Celebrex Page(s): 30.

Decision rationale: The CA MTUS states that Celebrex (Celecoxib) is a non-steroidal anti-inflammatory drug (NSAID) that is a COX-2 selective inhibitor, a drug that directly targets COX-2, an enzyme responsible for inflammation and pain. Unlike other NSAIDs, Celebrex does not appear to interfere with the antiplatelet activity of aspirin and is bleeding neutral when patients are being considered for surgical intervention or interventional pain procedures. Celebrex may be considered if the patient has a risk of GI complications, but not for the majority of patients. Generic NSAIDs and COX-2 inhibitors have similar efficacy and risks, when used for less than 3 months. In this case, the patient had gastritis from traditional NSAID therapy. However, there is no documentation of the medication's pain relief effectiveness or functional improvement. The medical necessity of the requested medication has not been established. The requested medication is not medically necessary.

Robaxin 500mg #60: 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, Antispasmodics Page(s): 63. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Robaxin.

Decision rationale: The ODG states that Robaxin (Methocarbamol) is an antispasmodic agent, under the classification of skeletal muscle relaxants for pain. The mechanism of action is unknown, but appears to be related to central nervous system depressant effects with related sedative properties. According to the CA MTUS Guidelines, muscle relaxants are not considered any more effective than non-steroidal anti-inflammatory medications alone. They are not recommended for the long-term treatment of chronic pain. In this case, there are no muscle spasms documented on physical exam. There is no documentation of objective functional improvement from any previous use of this medication. Based on the currently available information, the medical necessity for Robaxin, has not been established. The requested medication is not medically necessary.