

Case Number:	CM15-0035752		
Date Assigned:	03/27/2015	Date of Injury:	12/09/2013
Decision Date:	05/06/2015	UR Denial Date:	01/29/2015
Priority:	Standard	Application Received:	02/25/2015

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, Pain Management

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 43 year old male who sustained an industrial fall injury from a ladder on December 9, 2013. The injured worker was diagnosed with a fracture of the left hand which was initially casted, closed head injury, impingement syndrome of the left shoulder, discogenic lumbar condition with radicular component down the lower extremity, internal derangement of the left knee, ankle pain, left wrist pain with palmar angulation of the radius, and chronic pain syndrome with associated weight gain, sleep disturbance and depression. Diagnostic studies to date include magnetic resonance imaging (MRI) lumbar spine in August 2014, magnetic resonance imaging (MRI) left wrist in June 2014 and magnetic resonance imaging (MRI) left knee. Treatment to date have included 2 injections to the wrist, soft and rigid wrist brace, knee brace, hot/cold wraps, transcutaneous electrical nerve stimulation (TEN's) unit, back brace, physical therapy to the knee (6 sessions), approval for a psychiatric evaluation and medications. The injured worker is declining further injections. According to the primary treating physician's progress report on January 19, 2015, the patient continues to experience left wrist pain and cannot raise the left arm, ankle, lower back and knee pain. Exam of the ankle demonstrated limited range of motion with circumferential pain along the medial and lateral joint line. Examination of the left wrist demonstrated tenderness along the radioulnar and radiocarpal joints. The left shoulder revealed tenderness of the rotator cuff, impingement and abduction with shrugging no more than 90 degrees. The lumbar spine was tender to palpation. Current medications are listed as Trazadone, Effexor SR, Flexeril, Norco, Tramadol, Topamax, Neurontin, Lunesta, LidoPro Cream and Protonix. Treatment plan consists of medication refills,

diagnostic testing, neurologist consultation for headaches and psychiatrist consultation and rescheduling a psychological evaluation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Trazodone 50mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-depressants for chronic pain.

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, Sleep Medication, Insomnia treatment.

Decision rationale: Regarding the request for trazodone 50mg #60, California MTUS guidelines are silent regarding the use of sedative hypnotic agents. ODG recommends the short-term use (usually two to six weeks) of pharmacological agents only after careful evaluation of potential causes of sleep disturbance. They go on to state the failure of sleep disturbances to resolve in 7 to 10 days, may indicate a psychiatric or medical illness. It is recommended that treatments for insomnia should reduce time to sleep onset, improve sleep maintenance, avoid residual effects and increase next-day functioning. Within the documentation available for review, there are no subjective complaints of insomnia, no discussion regarding how frequently the insomnia complaints occur or how long they have been occurring, no statement indicating what behavioral treatments have been attempted for the condition of insomnia, and no statement indicating how the patient has responded to trazodone treatment. In the absence of such documentation, the currently requested trazodone 50mg #60 is not medically necessary.

Effexor SR 75mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-depressants for chronic pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 Page(s): 13-16.

Decision rationale: Regarding the request for Effexor SR 75mg #60, guidelines state that antidepressants are recommended as a 1st line option for neuropathic pain and as a possibility for non-neuropathic pain. Guidelines go on to recommend a trial of at least 4 weeks. Assessment of treatment efficacy should include not only pain outcomes, but also an evaluation of function, changes in use of other analgesic medication, sleep quality and duration, and psychological assessment. Within the documentation available for review, there is no identification that the Effexor provides any specific analgesic effect (in terms of reduced numeric rating scale or percent reduction in pain), or provides any objective functional improvement, reduction in opiate medication use, or improvement in psychological well-being. Additionally, if the Effexor is being prescribed to treat depression, there is no documentation of depression, and no objective

findings which would support such a diagnosis (such as a mini mental status exam, or even depressed mood). In the absence of clarity regarding those issues, the currently requested Effexor SR 75mg #60 is not medically necessary.

Flexeril 75mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants for chronic pain. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Workers Compensation Pain Procedure Summary.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 63-66 of 127.

Decision rationale: Regarding the request for Flexeril 7.5mg #60, Chronic Pain Medical Treatment Guidelines support the use of non-sedating muscle relaxants to be used with caution as a 2nd line option for the short-term treatment of acute exacerbations of pain. Guidelines go on to state that cyclobenzaprine specifically is recommended for a short course of therapy. Within the documentation available for review, there is no identification of a specific analgesic benefit or objective functional improvement as a result of the cyclobenzaprine. Additionally, it does not appear that this medication is being prescribed for the short-term treatment of an acute exacerbation, as recommended by guidelines. Finally, there is no documentation of failure of first-line treatment options, as recommended by guidelines. In the absence of such documentation, the currently requested Flexeril 7.5mg #60 is not medically necessary.

Protonix 20mg #60: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Workers Compensation - Pain Procedure Summary.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 68-69 of 127. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Proton Pump Inhibitors (PPIs).

Decision rationale: Regarding the request for Protonix 20mg #60, California MTUS states that proton pump inhibitors are appropriate for the treatment of dyspepsia secondary to NSAID therapy or for patients at risk for gastrointestinal events with NSAID use. Additionally, ODG recommends Nexium, Protonix, Dexilant, and AcipHex for use as 2nd line agents, after failure of omeprazole or lansoprazole. Within the documentation available for review, there is no indication that the patient has complaints of dyspepsia secondary to NSAID use, a risk for gastrointestinal events with NSAID use, or another indication for this medication. Furthermore, there is no indication that the patient has failed first-line agents prior to initiating treatment with Protonix (a 2nd line proton pump inhibitor). In the absence of clarity regarding those issues, the currently requested Protonix 20mg #60 is not medically necessary.

Topamax 50mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy Drugs (AEDs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 16-21 of 127.

Decision rationale: Regarding request for Topamax 50mg #60, Chronic Pain Medical Treatment Guidelines state that anti-epilepsy drugs are recommended for neuropathic pain. They go on to state that a good outcome is defined as 50% reduction in pain and a moderate response is defined as 30% reduction in pain. Guidelines go on to state that after initiation of treatment, there should be documentation of pain relief and improvement in function as well as documentation of side effects incurred with use. The continued use of AEDs depends on improved outcomes versus tolerability of adverse effects. Within the documentation available for review, there is no identification of any specific analgesic benefit (in terms of percent reduction in pain or reduction of NRS), and no documentation of specific objective functional improvement. Additionally, there is no discussion regarding side effects from this medication. Antiepileptic drugs should not be abruptly discontinued but unfortunately there is no provision to modify the current request. As such, the currently requested Topamax 50mg #60 is not medically necessary.

Neurontin 600mg #180: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy Drugs (AEDs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 16-21 of 127.

Decision rationale: Regarding request for Neurontin 600mg #180, Chronic Pain Medical Treatment Guidelines state that anti-epilepsy drugs are recommended for neuropathic pain. They go on to state that a good outcome is defined as 50% reduction in pain and a moderate response is defined as 30% reduction in pain. Guidelines go on to state that after initiation of treatment, there should be documentation of pain relief and improvement in function as well as documentation of side effects incurred with use. The continued use of AEDs depends on improved outcomes versus tolerability of adverse effects. Within the documentation available for review, there is no identification of any specific analgesic benefit (in terms of percent reduction in pain or reduction of NRS), and no documentation of specific objective functional improvement. Additionally, there is no discussion regarding side effects from this medication. Antiepileptic drugs should not be abruptly discontinued but unfortunately there is no provision to modify the current request. As such, the currently requested Neurontin 600mg #180 is not medically necessary.

Lunesta 2mg #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Med Lett Drugs Ther. 2006 Feb 28, page 47 (12103):17-9, Eszopiclone (Lunesta).

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, Sleep Medication, Insomnia treatment.

Decision rationale: Regarding the request for Lunesta (eszopiclone), California MTUS guidelines are silent regarding the use of sedative hypnotic agents. ODG recommends the short-term use (usually two to six weeks) of pharmacological agents only after careful evaluation of potential causes of sleep disturbance. They go on to state the failure of sleep disturbances to resolve in 7 to 10 days, may indicate a psychiatric or medical illness. Within the documentation available for review, there are no subjective complaints of insomnia, no discussion regarding how frequently the insomnia complaints occur or how long they have been occurring, no statement indicating what behavioral treatments have been attempted for the condition of insomnia, and no statement indicating how the patient has responded to Lunesta treatment. Finally, there is no indication that Lunesta is being used for short term use as recommended by guidelines. In the absence of such documentation, the currently requested Lunesta (eszopiclone) is not medically necessary.

Lidopro cream 1 bottle: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 111-113 of 127. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: <http://dailymed.nlm.nih.gov/dailymed/lookup.cfm?setid=ef3f3597-94b9-4865-b805-a84b224a207e>.

Decision rationale: Regarding request for LidoPro, LidoPro contains Capsaicin 0.0325%, Lidocaine 4.5%, Menthol 10%, and Methyl Salicylate 27.5%. Chronic Pain Medical Treatment Guidelines state that any compounded product that contains at least one drug or drug class that is not recommended, is not recommended. Regarding use of capsaicin, guidelines state that it is recommended only as an option for patients who did not respond to or are intolerant to other treatments. Regarding the use of topical lidocaine, Chronic Pain Medical Treatment Guidelines recommend the use of topical lidocaine for localized peripheral pain after there has been evidence of a trial of the 1st line therapy such as tri-cyclic antidepressants, SNRIs, or antiepileptic drugs. Guidelines go on to state that no commercially approved topical formulations of lidocaine cream, lotion, or gel are indicated for neuropathic pain. Within the documentation available for review, there is no indication that the patient has failed first-line therapy recommendations. Furthermore, guidelines do not support the use of topical lidocaine preparations which are not in patch form. In addition, there is no indication that the patient has been intolerant to or did not respond to other treatments prior to the initiation of capsaicin

therapy. In the absence of clarity regarding those issues, the currently requested LidoPro is not medically necessary.

MRI with contrast under fluoroscopy: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 214 and 343. CharFormat Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Workers Compensation (TWC); Shoulder Procedure Summary (updated 8/27/14), ODG-TWC Knee & Leg Procedure Summary (updated 10/27/14).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343, algorithms 13-1 and 13-3. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee & Leg, MRI.

Decision rationale: Regarding the request for MRI knee, CA MTUS and ACOEM note that, in absence of red flags (such as fracture/dislocation, infection, or neurologic/vascular compromise), diagnostic testing is not generally helpful in the first 4-6 weeks. After 4-6 weeks, if there is the presence of locking, catching, or objective evidence of ligament injury on physical exam, MRI is recommended. ODG recommends plain radiographs in the absence of signs/symptoms of internal derangement or red flags. Within the medical information made available for review, there is no documentation that radiographs are non-diagnostic, identification of any red flags or documentation that conservative treatment aimed towards the knee has failed. In the absence of such documentation, the currently requested MRI is not medically necessary.

EMG/NCV bilateral lower extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 304. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Workers Compensation (TWC); Low Back Procedure Summary (updated 1/14/15).

MAXIMUS 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 Chapter, Electrodiagnostic Studies.

Decision rationale: Regarding the request for EMG/NCV of the lower extremities, Occupational Medicine Practice Guidelines state that unequivocal objective findings that identify specific nerve compromise on the neurologic exam are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery. When a neurologic examination is less clear however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. They go on to state that electromyography may be useful to identify subtle focal neurologic dysfunction in patients with low back symptoms lasting more than 3 to 4 weeks. ODG states that nerve conduction studies are not recommended for back conditions. They go on to state that there is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. Within the documentation available for review, there are no physical examination findings

supporting a diagnosis of specific nerve compromise. Additionally, if such findings are present but have not been documented, there is no documentation that the patient has failed conservative treatment directed towards these complaints. In the absence of such documentation, the currently requested EMG/NCV of the lower extremities is not medically necessary.

Subacromial injection: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 213. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Workers Compensation (TWC) Shoulder Procedure Summary (updated 8/27/14).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Shoulder Page(s): 204. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder.

Decision rationale: Regarding the request for shoulder subacromial injection, Chronic Pain Medical Treatment Guidelines support the use of a subacromial injection if pain with elevation significantly limits activity following failure of conservative treatment for 2 or 3 weeks. They go on to recommend the total number of injections should be limited to 3 per episode, allowing for assessment of benefits between injections. Official Disability Guidelines recommend performing shoulder injections guided by anatomical landmarks alone. Guidelines go on support the use of corticosteroid injections for adhesive capsulitis, impingement syndrome, or rotator cuff problems which are not controlled adequately by conservative treatment after at least 3 months, when pain interferes with functional activities. Guidelines state that a 2nd injection is not recommended if the 1st has resulted in complete resolution of symptoms, or if there has been no response. Within the documentation available for review, there is no indication of pain with elevation that significantly limits activity following failure of conservative treatment for 2 or 3 weeks (strengthening and NSAIDs). As such, the currently requested shoulder subacromial injection is not medically necessary.

Neurology Consult: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Workers Compensation (TWC); Pain Procedure Summary (updated 11/21/14).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Occupational Medicine Practice Guidelines, Independent Medical Examinations and Consultations Chapter, Page 127.

Decision rationale: Regarding the request for neurology consultation, California MTUS does not address this issue. ACOEM supports consultation if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. Within the documentation available for review, the requesting physician has not identified any uncertain or extremely complex diagnoses or any concurrent

psychosocial factors. Additionally, there is no documentation that the physician has tried to address these issues prior to considering a referral. In the absence of such documentation, the currently requested neurology consultation is not medically necessary.

Physiatry Consult: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Workers Compensation (TWC); Pain Procedure Summary (updated 11/21/14).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Occupational Medicine Practice Guidelines, Independent Medical Examinations and Consultations Chapter, Page 127.

Decision rationale: Regarding the request for physiatry consultation, California MTUS does not address this issue. ACOEM supports consultation if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. Within the documentation available for review, the requesting physician has not identified any uncertain or extremely complex diagnoses or any concurrent psychosocial factors. Additionally, there is no documentation that the physician has tried to address these issues prior to considering a referral. In the absence of such documentation, the currently requested physiatry consultation is not medically necessary.