

<b>Case Number:</b>	CM15-0065992		
<b>Date Assigned:</b>	04/13/2015	<b>Date of Injury:</b>	10/02/2001
<b>Decision Date:</b>	07/07/2015	<b>UR Denial Date:</b>	04/03/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/07/2015

### 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: Arizona, Michigan

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 54 year old female who sustained an industrial injury on October 2, 2001. The injured worker was diagnosed with failed lumbar back syndrome and lumbar degenerative disc disease with radiculopathy. Treatment to date includes diagnostic testing, surgery, physical therapy and medications. The injured worker is status post L2-3 fusion (2007) followed by four subsequent revisions and hardware removal. According to the primary treating physician's progress report on March 9, 2015, the injured worker continues to experience low back pain and fatigue. The injured worker is independent with activities of daily living, drives and able to walk 20-30 minutes without assistive devices. The injured worker rates her pain as 7/10. Examination notes tenderness to palpation at T4-5 level. Urine drug screens have been consistent. Current medications are listed as Gabapentin, Skelaxin, Percocet, OxyContin, Lunesta and Baclofen. Treatment plan consists of activity as tolerated, discontinuing Baclofen; restart Skelaxin, thoracic spine magnetic resonance imaging (MRI) and the current requests for 6 trigger point injections for the lumbar spine, trial of Dilaudid, OxyContin, Percocet, Gabapentin, Lunesta and Lidoderm Patches.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**6 Trigger point injections:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Trigger point injections Page(s): 122.

**Decision rationale:** Per the MTUS, Trigger point injections are recommended only for myofascial pain syndrome as indicated below, with limited lasting value. Not recommended for radicular pain. Trigger point injections with an anesthetic such as bupivacaine are recommended for non-resolving trigger points, but the addition of a corticosteroid is not generally recommended. A trigger point is a discrete focal tenderness located in a palpable taut band of skeletal muscle, which produces a local twitch in response to stimulus to the band. Trigger points may be present in up to 33-50% of the adult population. Myofascial pain syndrome is a regional painful muscle condition with a direct relationship between a specific trigger point and its associated pain region. These injections may occasionally be necessary to maintain function in those with myofascial problems when myofascial trigger points are present on examination. Not recommended for typical back pain or neck pain. Per the MTUS, Criteria for the use of Trigger point injections: Trigger point injections with a local anesthetic may be recommended for the treatment of chronic low back or neck pain with 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; (3) Medical management therapies such as ongoing stretching exercises, physical therapy, NSAIDs and muscle relaxants have failed to control pain; (4) Radiculopathy is not present (by exam, imaging, or neuro-testing); (5) Not more than 3-4 injections per session; (6) No repeat injections unless a greater than 50% pain relief is obtained for six weeks after an injection and there is documented evidence of functional improvement; (7) Frequency should not be at an interval less than two months; (8) Trigger point injections with any substance (e.g., saline or glucose) other than local anesthetic with or without steroid are not recommended. The guidelines recommend 3-4 injections per session and there is nothing in the injured workers presentation to warrant deviating from the guidelines, therefore the request for 6 trigger point injections is not medically necessary.

**Lunesta 3mg #30:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness and Stress / Eszopicolone (Lunesta).

**Decision rationale:** The MTUS did not specifically address the use of lunesta, therefore other guidelines were consulted. Per the ODG, "Not recommended for long-term use, but recommended for short-term use. See Insomnia treatment. See also the Pain Chapter. Recommend limiting use of hypnotics to three weeks maximum in the first two months of injury only, and discourage use in the chronic phase. While sleeping pills, so-called minor tranquilizers, and anti-anxiety agents are commonly prescribed in chronic pain, pain specialists rarely, if ever, recommend them for long-term use. 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, eszopicolone (Lunesta) had a Hazard ratio for death of 30.62 (C.I., 12.90 to

72.72), compared to zolpidem at 4.82 (4.06 to 5.74). In general, receiving hypnotic prescriptions was associated with greater than a threefold increased hazard of death even when prescribed less than 18 pills/year. (Kripke, 2012) The FDA has lowered the recommended starting dose of eszopiclone (Lunesta) from 2 mg to 1 mg for both men and women. Previously recommended doses can cause impairment to driving skills, memory, and coordination as long as 11 hours after the drug is taken. Despite these long-lasting effects, patients were often unaware they were impaired." A review of the injured workers medical records do not reveal extenuating circumstances that would warrant deviating from the guidelines, therefore the request for lunesta is not medically necessary.

**Lidoderm patches #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): 111-113.

**Decision rationale:** Per the MTUS, topical analgesics are recommended as an option, they are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anti-convulsants have failed. Many agents are compounded as monotherapy or in combination for pain control, any compounded product that contains at least one drug or drug class that is not recommended is not recommended. A review of the injured workers medical records that are available to me does not show a trial of recommended first line agents that have failed, therefore the request for Lidoderm patches #30 is not medically necessary.

**Gabapentin 300mg #120: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs (AED's) Page(s): 16-22.

**Decision rationale:** Per the MTUS, antiepilepsy drugs are recommended for neuropathic pain. Gabapentin is considered first line treatment for neuropathic pain. The choice of specific agents reviewed below will depend on the balance between effectiveness and adverse reactions. A good response to the use of AEDs has been defined as a 50% reduction in pain and a moderate response as a 30% reduction. It has been reported that a 30% reduction in pain is clinically important to patients and a lack of response of this magnitude may be the trigger for the following: (1) a switch to a different first-line agent (TCA, SNRI or AED are considered first- line treatment); or (2) combination therapy if treatment with a single drug agent fails. (Eisenberg, 2007) (Jensen, 2006) 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. Unfortunately a review of the injured workers medical records that are available to me did not reveal documentation of improvement in pain or function with the use of gabapentin as required by the guidelines and without this information medical necessity for continued use cannot be established. The request is not medically necessary.

**Unknown prescription trial of dilaudid:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids  
Page(s): 74-96 (78, 89, 95).

**Decision rationale:** Per the MTUS, opioids should be discontinued if there is no overall improvement in function, unless there are extenuating circumstances, Opioids should be continued if the patient has returned to work or has improved functioning and pain. Ongoing management actions should include prescriptions from a single practitioner, taken as directed and all prescriptions from a single pharmacy. The lowest possible dose should be prescribed to improve pain and function. Documentation should follow the 4 A's of analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors. Long term users of opioids should be regularly reassessed. In the maintenance phase the dose should not be lowered if it is working. Also, patients who receive opioid therapy may sometimes develop unexpected changes in their response to opioids, which includes development of abnormal pain, change in pain pattern, persistence of pain at higher levels than expected when this happens opioids can actually increase rather than decrease sensitivity to noxious stimuli. it is important to note that a decrease in opioid efficacy should not always be treated by increasing the dose or adding other opioids, but may actually require weaning. Unfortunately the request is not accompanied by a dose, frequency or quantity and without this information medical necessity cannot be determined. The request is not medically necessary.