

Case Number:	CM15-0078657		
Date Assigned:	05/20/2015	Date of Injury:	09/29/2010
Decision Date:	09/25/2015	UR Denial Date:	04/10/2015
Priority:	Standard	Application Received:	04/24/2015

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: 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 is a 44-year-old male who sustained an industrial injury on 9/29/10. The injured worker has complaints of low back pain and bilateral leg pain. The documentation noted that the injured worker had an antalgic gait with ability for heel and toe raise and had no tenderness to palpation of lumbar spine region. The diagnoses have included degeneration of lumbar or lumbosacral intervertebral disc; thoracic or lumbosacral neuritis or radiculitis, unspecified and lumbago. Treatment to date has included nucynta; topical creams; electromyography/nerve conduction study on 10/23/13 and a magnetic resonance imaging (MRI) of the lumbar spine on 10/11/13 showed L4-5 mild left foraminal disc protrusion creating a small neural foramen, this was unchanged since the prior study. The request was for nucynta 50mg #30; topical pain cream (KOKUA#3), (ketamine 10%, baclofen 2%, cyclobenzaprine 2%, gabapentin 6%, lidocaine 5%); clonazepam 50mg #30; retrospective urine drug screen; acupuncture referral and sacroiliac joint evaluation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Topical Pain Cream (KOKUA #3): (Keto 10%, Baclo 2%, Cyclobenzaprine 2%, Gaba 6%, Lido 5%): 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.

Decision rationale: Based on the 04/01/15 progress report provided by treating physician, the patient presents with low back pain rated 5-7/10 that radiates to the bilateral legs. The patient is status post right knee arthroscopy and meniscus repair March 2010. The request is for TOPICAL PAIN CREAM (KOKUA #3): (KETO 10%, BACLO 2%, CYCLOBENZAPRINE 2%, GABA 6%, LIDO 5%). Patient's diagnosis per Request for Authorization form dated 04/01/15, includes degeneration of lumbar disc, lumbago, and thoracic or lumbosacral neuritis or radiculitis. Physical examination to the lumbar spine on 04/01/15 revealed decreased range of motion, especially with patient refusal to extend due to severe pain. Positive straight leg raise test on the right. Treatment to date has included imaging and electrodiagnostic studies, lumbar ESI, and medications. Patient's medications include Nucynta, Clonazepam and Lyrica. Patient's work status not provided. MTUS has the following regarding topical creams (p111, chronic pain section): "Topical Analgesics: Non-steroidal antiinflammatory agents (NSAIDs): The efficacy in clinical trials for this treatment modality has been inconsistent and most studies are small and of short duration. Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but either not afterward, or with a diminishing effect over another 2-week period. MTUS further states, "Non FDA-approved agents: Ketoprofen: This agent is not currently FDA approved for a topical application. It has an extremely high incidence of photocontact dermatitis. Topical lidocaine, in the formulation of a dermal patch (Lidoderm) has been designated for orphan status by the FDA for neuropathic pain. Lidoderm is also used off-label for diabetic neuropathy. No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. Gabapentin: Not recommended. Baclofen: Not recommended. Other muscle relaxants: There is no evidence for use of any other muscle relaxant as a topical product." Per 04/01/15 report, treater states "when using the topical samples [the patient] reports being able to reduce the need for oral pain medication without the side effects but the pain relief." However, MTUS page 111 states that if one of the compounded topical products is not recommended, then the entire product is not. In this case, the requested topical compound contains Lidocaine, Ketoprofen, Baclofen, Cyclobenzaprine, and Gabapentin, which are not supported for topical use in lotion form, per MTUS. This request is not in accordance with guideline indications. Therefore, the request IS NOT medically necessary.

Nucynta 50 mg #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 (ODG): <http://www.odg-twc.com/odgtwc/pain.htm#Tapentadol>; <http://www.odg-twc.com/odgtwc/pain.htm#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: Based on the 04/01/15 progress report provided by treating physician, the patient presents with low back pain rated 5-7/10 that radiates to the bilateral legs. The patient is status post right knee arthroscopy and meniscus repair March 2010. The request is for NUCYNTA 50 MG #30. Patient's diagnosis per Request for Authorization form dated 04/01/15 includes degeneration of lumbar disc, lumbago, and thoracic or lumbosacral neuritis or radiculitis. Physical examination to the lumbar spine on 04/01/15 revealed decreased range of motion, especially with patient refusal to extend due to severe pain. Positive straight leg raise test on the right. Treatment to date has included imaging and electrodiagnostic studies, lumbar ESI, and medications. Patient's medications include Nucynta, Clonazepam and Lyrica. Patient's work status not provided. MTUS Guidelines pages 88 and 89 states: "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 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. MTUS p77 states "function should include social, physical, psychological, daily and work activities, and should be performed using a validated instrument or numerical rating scale." Pages 80, 81 of MTUS also states: "There are virtually no studies of opioids for treatment of chronic lumbar root pain with resultant radiculopathy," and for chronic back pain, it "Appears to be efficacious but limited for short-term pain relief, and long-term efficacy is unclear (>16 weeks), but also appears limited." Nucynta is included in sole provided progress report dated 04/01/15. It is not known when this medication was initiated. Per 04/01/15 report, "PDMP/CURES report was obtained and reviewed with no aberrant activity noted. An opioid informed consent and contract was given. . . 11 panel urine drug screen was administered today and was negative for opiates. . . patient took his last dose of Nucynta this morning. The patient alternates the use of his clonazepam and Lyrica. . . PHQ-9 depression index . . . indicate moderately severe depression symptoms. " Medications provide 30% pain relief. In this case, treater has addressed analgesia and aberrant behavior in discussing the 4A's. However, there are no specific examples of ADL's demonstrating significant functional improvement. MTUS p77 states: "function should include social, physical, psychological, daily and work activities, and should be performed using a validated instrument or numerical rating scale." Furthermore, the patient has been taking Nucynta for an unknown period, and UDS did not show opioids, which indicates inconsistency with prescribed medications. In addition, MTUS does not clearly support chronic opiate use for this kind of condition, chronic low back pain and radiculopathy. Therefore, the request IS NOT medically necessary.

Clonazepam 50 mg #30: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines benzodiazepines Page(s): 24.

Decision rationale: Based on the 04/01/15 progress report provided by treating physician, the patient presents with low back pain rated 5-7/10 that radiates to the bilateral legs. The patient is status post right knee arthroscopy and meniscus repair March 2010. The request is for CLONOZEPAM 50 MG #30. Patient's diagnosis per Request for Authorization form dated 04/01/15 includes degeneration of lumbar disc, lumbago, and thoracic or lumbosacral neuritis or radiculitis. Physical examination to the lumbar spine on 04/01/15 revealed decreased range of

motion, especially with patient refusal to extend due to severe pain. Positive straight leg raise test on the right. Treatment to date has included imaging and electrodiagnostic studies, lumbar ESI, and medications. Patient's medications include Nucynta, Clonazepam and Lyrica. Patient's work status not provided. MTUS Guidelines page 24 states: "benzodiazepines are not recommended for long-term use because long-term efficacies are unproven and there is a risk of dependence." Per 04/01/15 report: "PDMP/CURES report was obtained and reviewed with no aberrant activity noted. An opioid informed consent and contract was given. . . 11 panel urine drug screen was administered today and was negative for opiates. . . patient took his last dose of Nucynta this morning. The patient alternates the use of his clonazepam and Lyrica. . . PHQ-9 depression index. . . indicate moderately severe depression symptoms. " Medications provide 30% pain relief. It is not known how long the patient has been prescribed Clonazepam. MTUS and ODG guidelines do not support the long-term use of benzodiazepines, thus the request for additional Clonazepam cannot be warranted. This request is not in accordance with guidelines. Therefore, the request IS NOT medically necessary.

Retro: Urine Drug Screen (UDS): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation ODG: <http://www.odg-twc.com>.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Drug Testing Page(s): 43. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain chapter under Urine Drug Testing states: Patients at "low risk" of addiction/aberrant behavior should be tested.

Decision rationale: Based on the 04/01/15 progress report provided by treating physician, the patient presents with low back pain rated 5-7/10 that radiates to the bilateral legs. The patient is status post right knee arthroscopy and meniscus repair March 2010. The request is for RETRO: URINE DRUG SCREEN (UDS). Patient's diagnosis per Request for Authorization form dated 04/01/15 includes degeneration of lumbar disc, lumbago, and thoracic or lumbosacral neuritis or radiculitis. Physical examination to the lumbar spine on 04/01/15 revealed decreased range of motion, especially with patient refusal to extend due to severe pain. Positive straight leg raise test on the right. Treatment to date has included imaging and electrodiagnostic studies, lumbar ESI, and medications. Patient's medications include Nucynta, Clonazepam and Lyrica. Patient's work status not provided. MTUS Chronic Pain Medical Treatment Guidelines, for Testing, pg 43 states: Recommended as an option, using a urine drug screen to assess for the use or the presence of illegal drugs. ODG-TWC, Pain chapter under Urine Drug Testing states: Patients at "low risk" of addiction/aberrant behavior should be tested within six months of initiation of therapy and on a yearly basis thereafter. There is no reason to perform confirmatory testing unless the test is inappropriate or there are unexpected results. If required, confirmatory testing should be for the questioned drugs only. Treater has not provided reason for the request. MTUS and ODG do support UDS's for opiate management. The patient is undergoing opioid medication therapy. Per 04/01/15 report: "PDMP/CURES report was obtained and reviewed with no aberrant activity noted. An opioid informed consent and contract was given. . . 11 panel urine drug screen was administered today and was negative for opiates. . . patient took his last dose of Nucynta this morning." Given the patient is still undergoing opioid therapy, the request would appear to be indicated. MTUS does not specifically discuss the frequency that urine drug screens should be performed. However, ODG is more specific on the topic and recommends urine drug screens on a yearly basis if the patient is at low risk. In this case, treater has not provided patient's risk assessment, and a repeat UDS would not be indicated by guidelines.

Therefore, the request IS NOT medically necessary.

Acupuncture referral: Overturned

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, Chapter 7 Independent Medical Examinations and Consultations, page 127.

Decision rationale: Based on the 04/01/15 progress report provided by treating physician, the patient presents with low back pain rated 5-7/10 that radiates to the bilateral legs. The patient is status post right knee arthroscopy and meniscus repair March 2010. The request is for ACUPUNCTURE REFERRAL. Patient's diagnosis per Request for Authorization form dated 04/01/15 includes degeneration of lumbar disc, lumbago, and thoracic or lumbosacral neuritis or radiculitis. Physical examination to the lumbar spine on 04/01/15 revealed decreased range of motion, especially with patient refusal to extend due to severe pain. Positive straight leg raise test on the right. Treatment to date has included imaging and electrodiagnostic studies, lumbar ESI, and medications. Patient's medications include Nucynta, Clonazepam and Lyrica. Patient's work status not provided. ACOEM Practice Guidelines, 2nd Edition (2004), page 127 has the following: The occupational health practitioner may refer to other specialists 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. Acupuncture Medical Treatment Guidelines. MTUS pg. 13 states: "(i) Time to produce functional improvement: 3 to 6 treatments (ii) Frequency: 1 to 3 times per week (iii) Optimum duration: 1 to 2 months. (D) Acupuncture treatments may be extended if functional improvement is documented as defined in Section 9792. 20(e)." Treater has not provided reason for the request. ACOEM practice guidelines indicate that it may be appropriate for a physician to seek outside consultation when the course of care could benefit from a specialist. Provided reports do not indicated the patient had a trial of acupuncture. Given patient's condition and diagnosis, the request for acupuncture referral is warranted. This request appears reasonable and in accordance with guidelines. Therefore, the request IS medically necessary.

Sacroiliac (SI) joint eval: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, Chapter 7 Independent Medical Examinations and Consultations, page 127.

Decision rationale: Based on the 04/01/15 progress report provided by treating physician, the patient presents with low back pain rated 5-7/10 that radiates to the bilateral legs. The patient is status post right knee arthroscopy and meniscus repair March 2010. The request is for SACROILIAC (SI) JOINT EVAL. Treatment to date has included imaging and electrodiagnostic studies, lumbar ESI, and medications. Patient's medications include Nucynta, Clonazepam and Lyrica. Patient's work status not provided. ACOEM Practice Guidelines, 2nd Edition (2004), page 127 has the following: "The occupational health practitioner may refer to other specialists 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." Treater has

not provided reason for the request. Patient's diagnosis per Request for Authorization form dated 04/01/15 includes degeneration of lumbar disc, lumbago, and thoracic or lumbosacral neuritis or radiculitis. Physical examination to the lumbar spine on 04/01/15 revealed decreased range of motion, especially with patient refusal to extend due to severe pain. Positive straight leg raise test on the right. It would appear that the current treater feels uncomfortable with the patient's medical issues and has requested a sacroiliac joint evaluation. ACOEM practice guidelines indicate that it may be appropriate for a physician to seek outside consultation when the course of care could benefit from a specialist. In this case, the request for SI joint evaluation appears reasonable and may benefit the patient. Therefore, the request IS medically necessary.