

<b>Case Number:</b>	CM15-0085012		
<b>Date Assigned:</b>	05/07/2015	<b>Date of Injury:</b>	11/27/2001
<b>Decision Date:</b>	08/17/2015	<b>UR Denial Date:</b>	04/15/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/04/2015

### 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 50-year-old female injured worker suffered an industrial injury on 11/27/2001. The diagnoses included failed back syndrome, right trochanteric bursitis, and cervical radiculitis. The injured worker had been treated with spinal cord stimulator, epidural steroid injections and medications. On 3/18/2015, the treating provider reported low back pain 7/10 up to 9/10 radiating to the right lower extremity to the toes. On exam, the injured worker was in severe discomfort with an impaired gait. The sacroiliac joint and sciatic notch have moderate to severe tenderness. There were moderate spasms in the lumbar muscles with restricted painfully range of motion along with decreased sensations in the right lower extremity. The treatment plan included Toradol 60 mg/Dep Medrol 80 mg injection, Fentanyl transdermal system, Norco, Pristiq, Neurontin, Skelaxin and Caudal epidural.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Toradol 60 mg/Dep Medrol 80 mg injection, in office (retro 3/18/15): Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-71. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) NSAIDs.

**Decision rationale:** Ketorolac (Toradol) is a non-steroidal anti-inflammatory drug (NSAID). The oral form is only recommended for short-term (up to 5 days) management of moderately severe acute pain that requires analgesia at the opioid level, and only as a continuation following IV or IM dosing, if necessary. This medication is not indicated for minor or chronic painful conditions. In this case, there is no documentation of an acute exacerbation of pain. There is no evidence of decreased VAS scores or a decrease in medication use. The guidelines do not recommend Toradol for chronic pain, as in this case. Medical necessity for a Toradol injection has not been established. The requested medication is not medically necessary.

**DP 25 mcg/hr Qty 15, 1 patch every 48-72 hrs (Fentanyl transdermal system):** 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 Opioids Page(s): 91-97. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Opioids.

**Decision rationale:** According to ODG and MTUS, Fentanyl is a long-acting narcotic analgesic used to manage both acute and chronic pain. Fentanyl is an opioid analgesic with a potency of eighty times that of Morphine. Fentanyl transdermal (Duragesic) patches are indicated for the management of persistent chronic pain, which is moderate to severe requiring continuous, around-the-clock opioid therapy. Duragesic patches should only be used in patients who are currently on opioid therapy for which tolerance has developed. Patches are worn for a 72-hour period. In this case, 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. There is no documentation of the medication's pain relief effectiveness, functional status, or response to ongoing opioid analgesic therapy. In addition, there is no documentation risk assessment profile or an updated and signed pain contract between the provider and the patient. Medical necessity of the requested item 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.

**Norco 10/325 mg Qty 120:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-95, 124.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 91-97. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Opioids.

**Decision rationale:** According to the CA MTUS and ODG, Norco 10/325mg (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, which recommends 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. The MTUS recommends urine drug screens for patients with poor pain control and to help manage patients at risk of abuse. There is no documentation of significant pain relief or increased function from the opioids used to date. In addition, there is no documentation of a urine drug screen program. Medical necessity of the requested item 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.

**Pristiq 50 mg Qty 30:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain Page(s): 13-16.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines SNRIs. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) SNRIs.

**Decision rationale:** Pristiq (Desvenlafaxine) is a member of the selective serotonin and norepinephrine reuptake inhibitors (SNRIs) class of antidepressants. It has FDA approval for treatment of depression and anxiety disorders. It is off-label recommended for the treatment of neuropathic pain, diabetic neuropathy, fibromyalgia, and headaches. It may have an advantage over tricyclic antidepressants due to lack of anticholinergic side effects. In this case, there is no documentation of any specific benefit from the use of this medication. According to the CA MTUS, 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. Medical necessity for the requested medication has not been established. The medication is not medically necessary.

**Neurontin (dispensed - unspecified dosage/qty):** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs) Page(s): 16-22.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin (Neurontin) Page(s): 49.

**Decision rationale:** Gabapentin (Neurontin) is an anti-epilepsy drug (AED) which has been shown to be effective for treatment of diabetic painful neuropathy and post-herpetic neuralgia and has been considered as a first-line treatment for neuropathic pain. The continued use of AEDs depends on improved outcomes versus tolerability of adverse effects. 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. In this case, there is no documentation of subjective or objective findings to continue the use of Neurontin. In addition, there is no documentation of the dosage or quantity of Gabapentin requested. Medical necessity for Neurontin has not been established. The requested medication is not medically necessary.

**Skelaxin (unspecified dosage/qty):** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 64-66.

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

**Decision rationale:** Metaxalone (Skelaxin) is reported to be a relatively non-sedating muscle relaxant. The exact mechanism of action is unknown, but the effect is presumed to be due to general depression of the central nervous system. A hypersensitivity reaction (rash) has been reported. It is to be used with caution in patients with renal and/or hepatic failure. Skelaxin is recommended as a second-line option for short-term (less than two weeks) treatment of acute LBP and for short-term treatment of acute exacerbations in patients with chronic LBP. According to the CA MTUS guidelines, muscle relaxants are not considered any more effective than non-steroidal anti-inflammatory medications alone. In this case, the available records show that the patient has not shown a documented benefit or any functional improvement from prior Skelaxin use. In addition, there is no documentation of the dosage or quantity of Skelaxin requested. Medical necessity for this muscle relaxant has not been established. The requested medication is not medically necessary.

**Caudal epidural:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs) Page(s): 46.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines ESIs Page(s): 46. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) ESIs.

**Decision rationale:** Caudal epidural steroid injections are a combination of a steroid and a local anesthetic that is delivered to the lower back to treat chronic back and lower extremity pain. The purpose of an epidural steroid injection (ESI) is to reduce pain and inflammation, thereby facilitating progress in more active treatment programs and reduction of medication use, but this treatment alone offers no significant long-term functional benefit. Radiculopathy (due to

herniated nucleus pulposus, but not spinal stenosis) must be documented. Objective findings on examination need to be present. The CA MTUS guidelines state radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. This patient has a history of failed back syndrome with subjective complaints and objective findings on physical exam. However, there is no MRI provided for review in this case. Medical necessity for the requested caudal ESI has not been established. The requested ESI is not medically necessary.