MAXIMUS Federal Services

Case Number:	CM14-0161362		
Date Assigned:	10/06/2014	Date of Injury:	03/24/2011
Decision Date:	11/07/2014	UR Denial Date:	08/27/2014
Priority:	Standard	Application Received:	10/01/2014

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 66-year-old female who reported an injury due to a trip and forward fall on 03/24/2011. On 08/20/2014, her diagnoses included lumbar sprain/strain, other knee internal derangement, old disruption of ligaments, tear of lateral cartilage or meniscus of the knee, other specified sites of knee and leg. Her complaints included lumbar spine pain rated 8/10 and bilateral knee pain rated 9/10. Her treatment plan included continuing her current medications. Her medications included gabapentin 300 mg, hydrocodone 10/325 mg, alprazolam 1 mg, tizanidine 4 mg, and 3 different compounded creams. There was no rationale included in this worker's chart. A request for authorization dated 08/20/2014 was included.

IMR ISSUES, DECISIONS AND RATIONALES

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

Gabapentin 300mg, QTY: 90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs)Gabapentin (Neurontin), Page(s): 16-22; 49.

Decision rationale: The request for Gabapentin 300mg, QTY: 90 is not medically necessary. Per the California MTUS Guidelines, antiepilepsy drugs are recommended for neuropathic pain,

primarily postherpetic neuralgia, and painful polyneuropathy with diabetic polyneuropathy being the most common examples. There are few randomized controlled trials directed at central pain. A good response for the use of antiepileptic medications is a 50% reduction in pain and a moderate response is a 30% reduction. Gabapentin has been shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first line treatment for neuropathic pain and has also been recommended for complex regional pain syndrome. There is no documentation submitted that this injured worker had complex regional pain syndrome or postherpetic neuralgia. Additionally, there was no frequency of administration included with the request. Therefore, this request for Gabapentin 300mg, QTY: 90 is not medically necessary.

Hydrocodone 10/325gm, QTY: 120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use of opioids Page(s): 76-80. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Opioids, Dosing

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

Decision rationale: The request for Hydrocodone 10/325gm, QTY: 120 is not medically necessary. The California MTUS Guidelines recommend ongoing review of opioid use including documentation of pain relief, functional status, appropriate medication use, and side effects. It should include current pain and intensity of pain before and after taking the opioid. Satisfactory response to treatment may be indicated by decreased pain, increased level of function, or improved quality of life. In most cases, analgesic treatment should begin with acetaminophen, aspirin, NSAIDs, and/or antidepressants. There was no documentation in the submitted chart regarding appropriate long term monitoring/evaluations including side effects, failed trials of acetaminophen, aspirin, NSAIDs, antidepressants, or quantified efficacy. Additionally, the formulation and dosage of the medication is incorrect in the request. Furthermore, there was no frequency specified in the request. Therefore, this request for Hydrocodone 10/325gm, QTY: 120 is not medically necessary.

Alprazolam 1mg, QTY: 30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

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

Decision rationale: The request for Alprazolam 1mg, QTY: 30 is not medically necessary. Per the California MTUS Guidelines, benzodiazepines are not recommended for long term use because long term efficacy is unproven and there is a risk of dependence. Most guidelines limit their use to 4 weeks. Tolerance occurs within weeks. The submitted documentation revealed that this worker has been using alprazolam since 05/01/2014, which exceeds the

recommendations in the guidelines. Additionally, the request did not contain a frequency of administration. Therefore, this request for Alprazolam 1mg, QTY: 30 is not medically necessary.

Tizanidine 4mg, QTY: 90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for Pain) Page(s): 63-66.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 63-66..

Decision rationale: The request for Tizanidine 4mg, QTY: 90 is not medically necessary. The California MTUS Guidelines recommended that muscle relaxants be used with caution as a second line option for short term treatment of acute exacerbations in patients with chronic low back pain. In most low back pain cases, they show no benefit beyond NSAIDs. Efficacy appears to diminish over time. Tizanidine is FDA approved for management of spasticity and unlabeled use for low back pain. Decisions are based on evidence based criteria. Muscle relaxants are supported for short term use only. Chronic use would not be supported by the guidelines. The documentation does not identify spasticity in this worker and there was no documentation of significant functional improvement with the use of this medication. Furthermore, there was no frequency specified in the request. The clinical information submitted failed to meet the evidence based guidelines for continued use of muscle relaxants. Therefore, this request for Tizanidine 4mg, QTY: 90 is not medically necessary.

Flurbiprofen 20%/Tramadol 20% in Mediderm base x30gm: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113..

Decision rationale: The request for Flurbiprofen 20%/Tramadol 20% in Mediderm base x30gm is not medically necessary. The California MTUS Guidelines refer to topical analgesics as largely experimental with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Many agents are compounded in combination for pain control including opioids and NSAIDs. There is little to no research to support the use of many of these agents. Any compounded product that contains at least 1 drug (or drug class) that is not recommended is not recommended. Flurbiprofen is not FDA approved for topical use in humans. The only FDA approved NSAID for topical application is Voltaren gel 1% (diclofenac). The body part or parts that were to have been treated with this cream were not identified in the request. Additionally, there was no frequency of application included in the request. Therefore, this request for Flurbiprofen 20%/Tramadol 20% in Mediderm base x30gm is not medically necessary.

Gabapentin 10%/Amitriptyline 10%/Dexamethorphan 10% in Mediderm basex 30gm: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113..

Decision rationale: The request for Gabapentin 10%/Amitriptyline 10%/Dexamethorphan 10% in Mediderm basex 30gm is not medically necessary. The California MTUS Guidelines refer to topical analgesics as 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 anticonvulsants have failed. Many agents are compounded in combination for pain control including anticonvulsants and antidepressants. There is little to no research to support the use of many of these agents. Any compounded product that contains at least 1 drug (or drug class) that is not recommended is not recommended. Gabapentin is not recommended. There is no peer reviewed literature to support its use. The body part or parts that have been treated with this cream were not identified in the request. Furthermore, there was no frequency of application included in the request. Therefore, this request for Gabapentin 10%/Amitriptyline 10%/Dexamethorphan 10% in Mediderm basex 30gm is not medically necessary.

Flurbiprofen 20%/Tramadol 20% in mediderm base x 210gm: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113..

Decision rationale: The request for Flurbiprofen 20%/Tramadol 20% in mediderm base x 210gm is not medically necessary. The California MTUS Guidelines refer to topical analgesics as 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 anticonvulsants have failed. Many agents are compounded in combination for pain control including opioids and NSAIDs. There is little to no research to support the use of many of these agents. Any compounded product that contains at least 1 drug (or drug class) that is not recommended is not recommended. Flurbiprofen is not FDA approved for topical use in humans. The only FDA approved NSAID for topical application is Voltaren gel 1% (diclofenac). The body part or parts that were to have been treated with this cream were not identified in the request. Additionally, there was no frequency of application included in the request. Therefore, this request for Flurbiprofen 20%/Tramadol 20% in mediderm base x 210gm is not medically necessary.