

Case Number:	CM14-0025884		
Date Assigned:	06/13/2014	Date of Injury:	03/26/2008
Decision Date:	08/28/2014	UR Denial Date:	02/24/2014
Priority:	Standard	Application Received:	02/28/2014

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, has a subspecialty in Pain Management 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 presented with a date of injury of 3/26/08. A utilization review determination dated 2/24/14 recommends non-certification of trigger point injections, Flexeril, Sonata, Neurontin, Lyrica, Zofran, Prevacid, AndroGel, and Dendracin. Trigger point injections were noted to have been completed in 9/2013/, 10/2013, and 11/2013. 2/10/14 medical report identifies low back pain radiating down the LLE 6/10. Pain worsened after 5-level interbody fusion 6/27/12. Spinal cord stimulator implanted on 8/8/13 provides 50-60% pain relief to the low back and radicular symptoms to the lower extremities. Patient has been able to significant cut back on the amount of MD Contin he takes daily with a goal to cut back further. His current medications enable him to function on a daily basis. He completed aqua therapy 1 month earlier and continues to go, paying out of pocket. On exam, there is lumbar tenderness with numerous trigger points which are palpable and tender. There is decreased ROM. There is hip tenderness. "Motor testing in the left lower extremity is between 4-4+/5 approximately with ankle dorsiflexors between 3-3+/5." Sensation is decreased along the lateral thigh and calf on the left. The trigger point was reported to have a discrete focal tenderness and produce a local twitch in response to stimulus.

IMR ISSUES, DECISIONS AND RATIONALES

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

FOUR (4) TRIGGER POINT INJECTIONS OF 10CC OF .25% BUPIVACAINE (RETROSPECTIVE, DOS:02/10/2014): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TRIGGER POINT INJECTIONS.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 Page(s): 122.

Decision rationale: Regarding the request for trigger point injections, Chronic Pain Medical Treatment Guidelines support the use of trigger point injections after 3 months of conservative treatment provided trigger points are present on physical examination. Repeat trigger point injections may be indicated provided there is greater than 50% pain relief obtained for six weeks after an injection and there is documented evidence of functional improvement, but the frequency should not be at an interval less than two months. Within the documentation available for review, it appears that trigger point injections have been provided approximately monthly and there is no indication of at least 50% pain relief for 6 weeks with evidence of functional improvement. In the absence of such documentation, the request for four (4) trigger point injections of 10cc of .25% Bupivacaine (retrospective, DOS: 02/10/2014) is not medically necessary and appropriate.

FLEXERIL 7.5MG (RETROSPECTIVE, DOS:02/10/2014): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MUSCLE RELAXANTS (FOR PAIN).

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, Chronic Pain Medical Treatment Guidelines support the use of nonsedating muscle relaxants to be used with caution as a 2nd line option for the short-term treatment of acute exacerbations of pain. Within the documentation available for review, while there is a generic statement that the medications allow the patient to remain functional, 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. In the absence of such documentation, the request for Flexeril 7.5mg (Retrospective, DOS:02/10/2014) is not medically necessary and appropriate.

SONATA 10MG (RETROSPECTIVE, DOS:02/10/2014): 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).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Insomnia treatment.

Decision rationale: The Official Disability Guidelines (ODG) does support it as a first-line medication, but they note that short-term use (7-10 days) is indicated with a controlled trial showing effectiveness for up to 5 weeks. Within the documentation available for review, there is no clear indication of efficacy to date and the medication appears to be utilized for longer than the short-term treatment recommended by ODG. In light of the above issues, the request for Sonata 10 mg (retrospective, DOS:02/10/2014) is not medically necessary and appropriate.

NEURONTIN 600MG (RETROSPECTIVE, DOS:02/10/2014): 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, Chronic Pain Medical Treatment Guidelines state that Antiepilepsy 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. MTUS guidelines 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, while there is a generic statement that the medications allow the patient to remain functional, 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. In the absence of such documentation, the request for Neurontin 600 mg (retrospective, DOS:02/10/2014) is not medically necessary and appropriate.

LYRICA 75MG (RETROSPECTIVE, DOS:02/10/2014): Upheld

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

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 Lyrica, Chronic Pain Medical Treatment Guidelines state that Antiepilepsy 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, while there is a generic statement that the medications allow the patient to remain functional, 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. In the absence of such documentation, the currently requested Lyrica is not medically necessary and appropriate.

ZOFRAN 4MG (RETROSPECTIVE, DOS:02/10/2014): 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).

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 Chapter, Antiemetics.

Decision rationale: Regarding the request for Zofran, the Official Disability Guidelines (ODG) states that antiemetic are not recommended for nausea and vomiting secondary to chronic opioid use. Guidelines go on to recommend that ondansetron is approved for postoperative use, nausea and vomiting secondary to chemotherapy, and acute use for gastroenteritis. Within the documentation available for review, there is no indication that the patient has nausea as a result of any of these diagnoses. Additionally, there are no subjective complaints of nausea in any of the recent progress reports provided for review. In the absence of clarity regarding those issues, the request for Zofran 4mg (retrospective, DOS:02/10/2014) is not medically necessary and appropriate.

PREVACID 30MG (RETROSPECTIVE, DOS:02/10/2014): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

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 rationale: Regarding the request for Prevacid, 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. 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. In light of the above issues, the request for Prevacid 30 mg (retrospective, DOS: 02/10/2014) is not medically necessary and appropriate.

ANDROGEL 1% (RETROSPECTIVE, DOS:02/10/2014): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS, TESTOSTERONE REPLACEMENT FOR HYPOGONADISM.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Testosterone replacement for hypogonadism (related to opioids).

Decision rationale: The Official Disability Guidelines (ODG) cites that testosterone replacement is recommended in limited circumstances for patients taking high-dose long-term opioids with documented low testosterone levels. Within the documentation available for review, there is no documentation of a low testosterone level for which replacement would be indicated. In the absence of such documentation, the currently requested AndroGel is not medically necessary.

DENDRACIN TOPICAL ANALGESIC CREAM (RETROSPECTIVE, DOS:02/10/2014):
Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines COMPOUNDED MEDICATIONS, TOPICALS.

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 rationale: Regarding the request for Dendracin, California MTUS cites that topical NSAIDs are indicated for “Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment: Recommended for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. Neuropathic pain: Not recommended as there is no evidence to support use.” Topical lidocaine (similar to benzocaine) is “Recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica).” Additionally, it is supported only as a dermal patch. Within the documentation available for review, none of the abovementioned criteria have been documented. Furthermore, there is no clear rationale for the use of topical medications rather than the FDA-approved oral forms for this patient. In light of the above issues, the request for Dendracin topical analgesic cream (retrospective, DOS:02/10/2014) is not medically necessary and appropriate.