

Case Number:	CM14-0162368		
Date Assigned:	10/27/2014	Date of Injury:	03/03/2001
Decision Date:	03/24/2015	UR Denial Date:	09/27/2014
Priority:	Standard	Application Received:	10/02/2014

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. 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, Tennessee
 Certification(s)/Specialty: Emergency 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 patient is a 59-year-old male who was injured on March 3, 2001. The patient continued to experience pain in bilateral hip, neck, back, right knee, and right foot. Physical examination was notable for normal axial compression test, normal straight leg raise, and crepitus of bilateral knees. Diagnoses included right internal knee derangement, right shoulder internal derangement, chronic left hip pain, left shoulder sprain/strain, and chronic low back pain. Treatment included medications, Requests for authorization for MS contin 60 mg #130, Percocet 10/325 mg #180, NSAID #240 with one refill, remeron 15 mg #60 with 1 refill, Lidoderm #60 with one refill, thermacare packs #60 with 1 refill, amrix 15 mg #30 with 1 refill, and nexium 40 mg #60 with 1 refill were submitted for consideration.

IMR ISSUES, DECISIONS AND RATIONALES

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

MS Contin 60mg #180: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Ongoing Management.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Guidelines Page(s): 74-96.

Decision rationale: MS contin is an extended release preparation of the opioid morphine. Chronic Pain Medical Treatment Guidelines state that opioids are not recommended as a first line therapy. Opioid should be part of a treatment plan specific for the patient and should follow criteria for use. Criteria for use include establishment of a treatment plan, determination if pain is nociceptive or neuropathic, failure of pain relief with non-opioid analgesics, setting of specific functional goals, and opioid contract with agreement for random drug testing. If analgesia is not obtained, opioids should be discontinued. The patient should be screened for likelihood that he or she could be weaned from the opioids if there is no improvement in pain of function. It is recommended for short-term use if first-line options, such as acetaminophen or NSAIDS have failed. In this case the patient had been taking MS contin since at least March 2014 and had not obtained analgesia. In addition there is no documentation that the patient has signed an opioid contract or is participating in urine drug testing. Criteria for long-term opioid use have not been met. The request should not be authorized.

Percocet 10/325mg #180: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Ongoing Management.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Guidelines Page(s): 11, 74-96.

Decision rationale: Percocet 10/325 is compounded medication containing oxycodone/acetaminophen. Chronic Pain Medical Treatment Guidelines state that opioids are not recommended as a first line therapy. Opioid should be part of a treatment plan specific for the patient and should follow criteria for use. Criteria for use include establishment of a treatment plan, determination if pain is nociceptive or neuropathic, failure of pain relief with non-opioid analgesics, setting of specific functional goals, and opioid contract with agreement for random drug testing. If analgesia is not obtained, opioids should be discontinued. The patient should be screened for likelihood that he or she could be weaned from the opioids if there is no improvement in pain of function. It is recommended for short-term use if first-line options, such as acetaminophen or NSAIDS have failed. Opioids may be a safer choice for patients with cardiac and renal disease than antidepressants or anticonvulsants. Acetaminophen is recommended for treatment of chronic pain & acute exacerbations of chronic pain. Acetaminophen overdose is a well-known cause of acute liver failure. Hepatotoxicity from therapeutic doses is unusual. Renal insufficiency occurs in 1 to 2% of patients with overdose. The recommended dose for mild to moderate pain is 650 to 1000 mg orally every 4 hours with a maximum of 4 g/day. In this case the patient had been taking Percocet since at least March 2014 and had not obtained analgesia. In addition there is no documentation that the patient has signed an opioid contract or is participating in urine drug testing. Criteria for long-term opioid use have not been met. The request should not be authorized.

NSAID #240g, 1 refill: 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 Pain Interventions and Guidelines Page(s): 111-112.

Decision rationale: This is topical non-steroidal anti-inflammatory drug (NSAID). Topical NSAIDS have been shown to be superior to placebo in the treatment of osteoarthritis, but only in the short term and not for extended treatment. The effect appears to diminish over time. Absorption of the medication can occur and may have systemic side effects comparable to oral form. Adverse effects for GI toxicity and renal function have been reported. It has not been evaluated for treatment of the spine, hip, or shoulder. In this case the patient has been using topical NSAID since at least March 2014 with little relief of pain. The duration of treatment increases the risk of adverse effects with little benefit. The request should not be authorized.

Remeron 15mg #60, refill 1: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines/Treatment in Workers Compensation, Pain

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Insomnia Treatment; Drugs for Insomnia Treatment Guidelines from The Medical Letter - July 1, 2012 (Issue 119) p. 57

Decision rationale: Remeron is mirtazapine, an antidepressant usually prescribed for insomnia. Proper sleep hygiene is critical to the individual with chronic pain and often is hard to obtain. Various medications may provide short-term benefit. Insomnia treatment should be based on etiology. Most medications have only been evaluated for short term use (less than 4 weeks). Pharmacological agents should only be used after careful evaluation of potential causes of sleep disturbance. Failure of sleep disturbance to resolve in a 7 to 10 day period may indicate a psychiatric and/or medical illness. Sedating antidepressants are often used to treat insomnia; however, there is less evidence to support their use for insomnia. They may be an option in patients with coexisting depression. Mirtazapine can cause sedation, increased appetite, weight gain, dizziness, dry mouth and constipation; febrile neutropenia has occurred rarely. The patient has been taking this medication since at least May 2014. Increased duration of treatment increases the risk adverse effects. The request should not be authorized.

Lidoderm #60, 1 refill: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Guidelines Page(s): 112. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Lidoderm (Lidocaine patch)

Decision rationale: Lidocaine is recommended for localized peripheral pain after the evidence of a trial for first-line therapy, such as an antidepressant or antiepileptic drug. It is only FDA approved for the treatment of post-herpetic neuralgia. The guidelines state that further research is needed to recommend this treatment for chronic neuropathic pain. Criteria for use of Lidoderm patches: a) Recommended for a trial if there is evidence of localized pain that is consistent with a neuropathic etiology.(b) There should be evidence of a trial of first-line neuropathy medications (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica).(c) This medication is not generally recommended for treatment of osteoarthritis or treatment of myofascial pain/trigger points.(d) An attempt to determine a neuropathic component of pain should be made if the plan is to apply this medication to areas of pain that are generally secondary to non-neuropathic mechanisms (such as the knee or isolated axial low back pain). One recognized method of testing is the use of the Neuropathic Pain Scale.(e) The area for treatment should be designated as well as number of planned (f) A Trial of patch treatment is recommended for a short-term period (no more than four weeks).(g) It is generally recommended that no other medication changes be made during the trial period.(h) Outcomes should be reported at the end of the trial including improvements in pain and function, and decrease in the use of other medications. If improvements cannot be determined, the medication should be discontinued.(i) Continued outcomes should be intermittently measured and if improvement does not continue, lidocaine patches should be discontinued.In this case the patient had been using Lidocaine patches since at least March 2014 and had not obtained analgesia. Criteria for use of Lidocaine patches have not been met. The request should not be authorized.

Thermacare Packs #60, 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 48.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back - Lumbar and Thoracic, Heat therapy

Decision rationale: ThermoCare is the brand name of a disposable heating pad made by [REDACTED]. Heat therapy is recommended as an option. A number of studies show continuous low-level heat wrap therapy to be effective for treating low back pain. One study compared the effectiveness of the [REDACTED] Back Plaster, the [REDACTED], and the [REDACTED] ThermoCare Heat Wrap, and concluded that the ThermoCare Heat Wrap is more effective than the other two. Active warming reduces acute low back pain during rescue transport. Combining continuous low-level heat wrap therapy with exercise during the treatment of acute low back pain significantly improves functional outcomes compared with either intervention alone or control. There is moderate evidence that heat wrap therapy provides a small short-term reduction in pain and disability in acute and sub-acute low-back pain, and that the addition of exercise further reduces pain and improves function. Heat therapy has been found

to be helpful for pain reduction and return to normal function. Heat therapy has been found to be helpful in acute and subacute back pain. In this case the patient's pain chronic, lasting more than 10 years. There is no evidence regarding the efficacy of heat wrap therapy with chronic back pain. The lack of evidence does not allow determination of efficacy or safety. The request should not be authorized.

Amrix 15mg #30, 1 refill: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Guidelines Page(s): 63.

Decision rationale: Amrix is the muscle relaxant, cyclobenzaprine. Cyclobenzaprine is recommended as an option, for a short course of therapy. It has been found to be more effective than placebo with greater adverse side effects. Its greatest effect is in the first 4 days. Treatment should be brief. Non-sedating muscle relaxants are recommended with caution as a second-line option for short-term treatment (less than two weeks) of acute exacerbations in patients with chronic LBP. Muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in most LBP cases, they show no benefit beyond NSAIDs in pain and overall improvement. Also there is no additional benefit shown in combination with NSAIDs. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. Sedation is the most commonly reported adverse effect of muscle relaxant medications. These drugs should be used with caution in patients driving motor vehicles or operating heavy machinery. In this case the patient had been taking amrix since at least March 2014. The duration of treatment surpasses the recommended short-term duration of two weeks. The request should not be authorized.

Nexium 40mg #60, 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-inflammatory Medications and Gastrointestinal Symptoms.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Guidelines Page(s): 68.

Decision rationale: Nexium is esomeprazole, a proton pump inhibitor (PPI). PPI's are used in the treatment of peptic ulcer disease and may be prescribed in patients who are using non-steroidal anti-inflammatory drugs and are at high risk for gastrointestinal events. Risk factors for high-risk events are age greater than 65, history of peptic ulcer, GI bleeding or perforation, concurrent use of ASA, corticosteroids, and/or an anticoagulant, or high dose/multiple NSAID (e.g., NSAID + low-dose ASA). The patient in this case was using oral NSAID medication and did not have any of the risk factors for a gastrointestinal event. The request should not be authorized.