

Case Number:	CM15-0014610		
Date Assigned:	02/02/2015	Date of Injury:	06/26/1997
Decision Date:	03/30/2015	UR Denial Date:	01/02/2015
Priority:	Standard	Application Received:	01/26/2015

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, Washington

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 63-year-old male who reported an injury on 06/26/1997. The mechanism of injury was not included. His diagnoses included chronic low back pain, spinal enthesopathy of lumbar region, arthropathy of lumbosacral facet joint, degenerative joint disease lumbar, and lumbar radiculopathy. His medications included Amitiza, Thermacare back and hip, Fiber Therapy, Lidoderm, tizanidine, Provigil, and OxyContin. A progress report dated 01/15/2015 documented there is a pain agreement on file. On physical exam it was noted the injured worker had tenderness to paravertebral muscles at L3-S1. Surrounding tissue tension/texture is in spasm. The injured worker rated his pain at an 8/10 referring to bilateral lower back and posterior leg on right side.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral paravertebral trigger point injections: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Trigger Point Injections. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back, Trigger Point Injections

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Trigger point injections Page(s): 122.

Decision rationale: The request for Bilateral paravertebral trigger point injections is not medically necessary. The California MTUS guidelines recommend lumbar trigger point injections only for myofascial pain syndrome as indicated below, with limited lasting value, and it is not recommended for radicular pain. Trigger point injections with a local anesthetic may be recommended for the treatment of chronic low back or neck pain with myofascial pain syndrome when all of the following criteria are met (1) Documentation of circumscribed trigger points with evidence upon palpation of a twitch response as well as referred pain; (2) Symptoms have persisted for more than three months; (3) Medical management therapies such as ongoing stretching exercises, physical therapy, NSAIDs and muscle relaxants have failed to control pain; (4) Radiculopathy is not present (5) Not more than 3-4 injections per session; (6) No repeat injections unless a greater than 50% pain relief is obtained for six weeks after an injection and there is documented evidence of functional improvement; (7) Frequency should not be at an interval less than two months; (8) Trigger point injections with any substance (e.g., saline or glucose) other than local anesthetic with or without steroid are not recommended. There is a lack of documentation regarding trigger points and their assessment, whether ongoing stretching exercises, physical therapy, NSAIDs and muscle relaxants have failed to control the pain, and documentation of the absence of radiculopathy. Therefore, the request for bilateral paravertebral trigger point injections is not medically necessary.

Amitiza 24 mcg #30, 30 days: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Opioids

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

Decision rationale: The request for Amitiza 24 mcg #30, 30 days is not medically necessary. The Official Disability Guidelines state constipation drug lubiprostone (Amitiza) shows efficacy and tolerability in treating opioid-induced constipation without affecting patients' analgesic response to the pain medications. Lubiprostone is a locally acting chloride channel activator that has a distinctive mechanism that counteracts the constipation associated with opioids without interfering with the opiates binding to their target receptors. There is a lack of documentation regarding opioid induced constipation, and a lack of documentation regarding a tried and failed attempt of the first line treatment. The request does not include dosing instructions. The request for Amitiza 24 mcg #30, 30 days is not medically necessary.

ThermaCare back/hip #30, 30 days: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck

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, Heat therapy

Decision rationale: The request for ThermaCare back/hip #30, 30 days is not medically necessary. The Official Disability Guidelines state that 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. 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. As the guidelines indicate that heat therapy provides short term reduction in pain and disability, and acute and subacute low back pain, and the injured worker is not in the acute phase, the request is not supported. The request does not include dosing instructions. The request for ThermaCare back/hip #30, 30 days is not medically necessary.

Fiber Therapy 500mg #240, 30 days: Upheld

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

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

Decision rationale: The request for Fiber Therapy 500mg #240, 30 days is not medically necessary. The Official Disability Guidelines state first-line therapy includes when prescribing an opioid, and especially if it will be needed for more than a few days, there should be an open discussion with the patient that this medication may be constipating, and the first steps should be identified to correct this. Simple treatments include increasing physical activity, maintaining appropriate hydration by drinking enough water, and advising the patient to follow a proper diet, rich in fiber. These can reduce the chance and severity of opioid-induced constipation and constipation in general. In addition, some laxatives may help to stimulate gastric motility. Other over-the-counter medications can help loosen otherwise hard stools, add bulk, and increase water content of the stool. If the first-line treatments do not work, there are other second-line options. There is a lack of documentation regarding the first line treatment for opioid induced constipation. As such, the request for Fiber Therapy is not supported. The request does not include dosing instructions. The request for Fiber Therapy 500mg #240, 30 days is not medically necessary.

Lidoderm 5% #30, 30 days: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidocaine, Lidoderm and Topical Analgesics. Decision based on Non-MTUS Citation Official Disability Guidelines, Lidoderm patches

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm (lidocaine patch) Page(s): 56-58.

Decision rationale: The request for Lidoderm 5% #30, 30 days is not medically necessary. The California MTUS guidelines state Lidoderm is the brand name for a lidocaine patch produced by Endo Pharmaceuticals. Topical lidocaine may be 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). This is not a first-line treatment and is only FDA approved for post-herpetic neuralgia. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than post-herpetic neuralgia. Formulations that do not involve a dermal-patch system are generally indicated as local anesthetics and anti-pruritics. There is a lack of documentation of a tried and failed first line treatment including tricyclic or SNRI antidepressants or an AED such as gabapentin or Lyrica. The request does not include placement or dosing instructions. The request for Lidoderm 5% #30, 30 days is not medically necessary.

Tizanidine HCL #120, 30 days: Upheld

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

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

Decision rationale: The request for Tizanidine HCL #120, 30 days is not medically necessary. The California MTUS guidelines state muscle relaxants are recommended with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP. Tizanidine (Zanaflex, generic available) is a centrally acting alpha2-adrenergic agonist that is FDA approved for management of spasticity; unlabeled use for low back pain. (Malanga, 2008) Eight studies have demonstrated efficacy for low back pain. (Chou, 2007) One study (conducted only in females) demonstrated a significant decrease in pain associated with chronic myofascial pain syndrome and the authors recommended its use as a first line option to treat myofascial pain. There is a lack of documentation regarding tried and failed first line treatment of muscle spasm. The guidelines state this is a short term treatment with acute exacerbations with chronic low back pain. The injured worker has not had red flags documented that would indicate this is an acute phase. The request does not include dosing instructions. The request for tizanidine HCL #120, 30 days is not medically necessary.

Provigil 200mg #30, 30 days: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation www.drugs.com/provigil.htm

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

Decision rationale: The request for Provigil 200mg #30, 30 days is not medically necessary. The California MTUS guidelines state Provigil is not recommended solely to counteract sedation effects of narcotics until after first considering reducing excessive narcotic prescribing. Use with caution as indicated below. Indications: Provigil is indicated to improve wakefulness in adult patients with excessive sleepiness associated with narcolepsy, obstructive sleep apnea, and shift work sleep disorder. Patients should have a complete evaluation with a diagnosis made in accordance with the International Classification of Sleep Disorders or DSM diagnostic classification. There is a lack of documentation regarding sedation effects the injured worker is experiencing. There is a lack of documentation of evaluation with a diagnosis made in accordance made with the International Classification of Sleep Disorders. The request does not include dosing instructions. The request for Provigil 200mg #30, 30 days is not medically necessary.

Oxycontin 80mg #60, 30 days: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, ongoing management Page(s): 78.

Decision rationale: The request for Oxycontin 80mg #60, 30 days is not medically necessary. The California MTUS guidelines state there are four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or nonadherent) drug-related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. There is a lack of documentation regarding a proper pain assessment, adverse side effects of this medication the injured worker may be experiencing, a current urine drug screen, documentation of a current review of CURES, a documented pain contract on file, and objective functional improvement after taking this medication. The request does not include dosing instructions. The request for Oxycontin 80mg #60, 30 days is not medically necessary.