

Case Number:	CM15-0016039		
Date Assigned:	02/04/2015	Date of Injury:	03/31/2005
Decision Date:	03/25/2015	UR Denial Date:	01/26/2015
Priority:	Standard	Application Received:	01/28/2015

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

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:

This injured worker is a 43 year old male who sustained an industrial injury on 3/31/05. He currently complains of worsening pain in his low back radiating down his left leg. He indicates weakness in the leg causing it to give out on him. The pain is worse since he underwent a hardware block done by his surgeon 2 weeks prior. He has since been to the emergency department to get pain medication. His current medications include Ambien, Prolosec, Zanaflex, Gralise, Cymbalta, oxycontin, Percocet and lorazepam. Diagnoses are post lumbar laminectomy syndrome; sacroilitis; thoracic or lumbosacral neuritis or radiculitis; lumbar radiculopathy and other pain disorders related to psychological factors. Treatments to date include sacroiliac joint injection (2009)(2010) and hardware block (2015) which were of no benefit. Progress note dated 1/7/15 indicate that compounded medications were requested to help him attain functional capacity through active participation in self-recovery efforts, to decrease oral pain medications. The provider indicated discontinuing Gralise and oxycontin. On 1/26/15 Utilization review non certified the requests for Oxycontin 20 mg # 60; Percocet 10/326 mg # 120; Transdermal Cream: Baclofen 2%, cyclobenzaprine 2%, gabapentin 6%, Lidocaine 2%, flurbiprofen 20% 240 GM #1; zanaflex 4 mg # 60 ; lumbar sacral orthosis-lumbar spine citing MTUS/ ACOEM; MTUS: Chronic Pain Medical Treatment Guidelines: Opioids; MTUS: Chronic Pain Medical Treatment Guidelines: Topical Analgesics; MTUS: Pain- Antispasmodics respectively.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar sacral orthosis - lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298, 301.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301.

Decision rationale: Regarding the request for lumbar orthosis, ACOEM guidelines state that lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. Within the documentation available for review, the patient is well beyond the acute stage of injury and there is no documentation of a pending/recent spine surgery, spinal instability, compression fracture, or another clear rationale for a brace in the management of this patient's chronic injury. In the absence of such documentation, the currently requested lumbar orthosis is not medically necessary.

Transdermal cream - Baclofen 2%, Cyclobenzaprine 2%, Gabapentin 6%, Lidocaine 2%, Flurbiprofen 20% 240gms: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113. Decision based on Non-MTUS Citation US National Institutes of Health (NIH) National Library of Medicine (NLM) PubMed, 2010, <http://www.ncbi.nlm.nih.gov/pubmed/>

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

Decision rationale: Regarding the request for baclofen/cyclobenzaprine/gabapentin/lidocaine/flurbiprofen, CA MTUS states that topical compound medications require guideline support for all components of the compound in order for the compound to be approved. 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 is "Recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tricyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica)." Additionally, it is supported only as a dermal patch. Muscle relaxants and antiepilepsy drugs are not supported by the CA MTUS for topical use. 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. Given all of the above, the requested baclofen/cyclobenzaprine/gabapentin/lidocaine/flurbiprofen is not medically necessary.

Percocet 10/325mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 75, 78.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use Page(s): 76-80.

Decision rationale: Regarding the request for Percocet, California Pain Medical Treatment Guidelines note that it is an opiate pain medication. Due to high abuse potential, close follow-up is recommended with documentation of analgesic effect, objective functional improvement, side effects, and discussion regarding any aberrant use. Guidelines go on to recommend discontinuing opioids if there is no documentation of improved function and pain. Within the documentation available for review, there is no indication that the medication is improving the patient's function or pain (in terms of specific examples of functional improvement and percent reduction in pain or reduced NRS), no documentation regarding side effects, and no discussion regarding aberrant use. As such, there is no clear indication for ongoing use of the medication. Opioids should not be abruptly discontinued, but unfortunately, there is no provision to modify the current request to allow tapering. In light of the above issues, the currently requested Percocet is not medically necessary.

Oxycontin 20mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 75, 78.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use Page(s): 76-80.

Decision rationale: Regarding the request for OxyContin, California Pain Medical Treatment Guidelines note that it is an opiate pain medication. Due to high abuse potential, close follow-up is recommended with documentation of analgesic effect, objective functional improvement, side effects, and discussion regarding any aberrant use. Guidelines go on to recommend discontinuing opioids if there is no documentation of improved function and pain. Within the documentation available for review, there is no indication that the medication is improving the patient's function or pain (in terms of specific examples of functional improvement and percent reduction in pain or reduced NRS), no documentation regarding side effects, and no discussion regarding aberrant use. As such, there is no clear indication for ongoing use of the medication. Opioids should not be abruptly discontinued, but unfortunately, there is no provision to modify the current request to allow tapering. In light of the above issues, the currently requested OxyContin is not medically necessary.

Zanaflex 4mg #60: Upheld

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

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

Decision rationale: Regarding the request for Zanaflex, Chronic Pain Medical Treatment Guidelines support the use of non-sedating 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, there is no identification of a specific analgesic benefit or objective functional improvement as a result of the medication. 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 currently requested Zanaflex is not medically necessary.