

Case Number:	CM15-0178387		
Date Assigned:	09/28/2015	Date of Injury:	10/02/2012
Decision Date:	11/20/2015	UR Denial Date:	08/14/2015
Priority:	Standard	Application Received:	09/11/2015

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: 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 injured worker is a 39 year old male, who sustained an industrial injury on 10-2-12. The injured worker was diagnosed as having other benign neoplasm of connective and other soft tissue side specific. Treatment to date has included physical therapy; psychotherapy; medications. Currently, the PR-2 notes dated 7-22-15 indicated the injured worker is in the office for a follow-up visit for chronic pain, myofascial pain and scar neuroma. The provider documents "location of pain: calf left side-patient denies radiation of pain. The quality of the pain: aching, burning, throbbing with duration of pain as constant but variable in intensity. Denies arthralgia but aggravated with standing; walking alleviated by rest. X-rays of the left tibia and Fibula were done on 9-23-14, 1) Normal left tibia-fibula series." The provider notes "discontinued medications" - Mobic, Orphenadrine, Lidocaine 5% patch and Ultram denied by insurance. He also notes 5-2015- referral for SCS (spinal cord stimulator) evaluation authorized on 3-2015. 4-2015 - CBT consult authorized. On physical examination the provider documents "palpation soft tissue tenderness noted over calf of left lower extremity (scar on left calf)." A PR- 2 dated 6-26-15, the provider documents "the patient really has received minimal treatment. I have made attempts to obtain physical therapy and during the course of the last year, he has received only 10 sessions of physical therapy." The provider continues documentation for medications: This patient presently is only authorized to take both Mobic and Lidocaine patches. My requests for Orphenadrine and hydrocodone have been non-certified. As the patient reported persistent disability, he was ultimately referred to a pain management specialist who has such experience with spinal cord stimulation. I wanted his opinion on whether or not a spinal

cord stimulator would help in the setting of musculoskeletal pain of the calf. It was of the opinion by this specialist that alternate therapy should be trialed before a spinal cord stimulator. He was not aware I have already trialed all of the medications and adjunctive therapies recommended. It is clear the patient is not interested in a spinal cord stimulator. Unfortunately, there is no surgery that would provide this patient benefit as well as the patient's pain most likely represents a scar neuroma. I have made attempts to obtain Botox injections for the patient as this can be beneficial in treating scar neuroma but again this met with a denial. Prescribed medications are documents as far back as 2-6-15. An EMG-NCV of the lower extremities on 5-7-15 reports: "Conclusion: normal study. No electrophysiological evidence for peroneal neuropathy at the fibular head, posterior tibial neuropathy at the ankle or lumbosacral radiculopathy. No electrophysiological evidence for sensory or motor polyneuropathy. Clinical correlation is always indicated. Temperature was assessed at time of testing and found to be >31C." A Request for Authorization is dated 9-10-15. A Utilization Review letter is dated 8-14-15 and non-certification was for 90 Hydrocodone 5mg-Acetaminophen 325mg; 60 Meloxicam 7.5mg; 30 Lidocaine 5% (700 mg/patch) and 60 Orphenadrine citrate 100mg. A request for authorization has been received for 90 Hydrocodone 5mg-Acetaminophen 325mg; 60 Meloxicam 7.5mg; 30 Lidocaine 5% (700 mg/patch) and 60 Orphenadrine citrate 100mg.

IMR ISSUES, DECISIONS AND RATIONALES

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

90 Hydrocodone 5mg-Acetaminophen 325mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use.

Decision rationale: The request is for the use of a medication in the opioid class. The MTUS guidelines state that for ongoing treatment with a pharmaceutical in this class, certain requirements are necessary. This includes not only adequate pain control, but also functional improvement. Four domains have been proposed for management of patients on opioids. This includes pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant drug-related behaviors. In this case, there is inadequate documentation of persistent functional improvement seen. As such, the request is not certified. All opioid medications should be titrated down slowly in order to prevent a significant withdrawal syndrome. Therefore not medically necessary.

60 Meloxicam 7.5mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic)/NSAIDs (non-steroidal anti-inflammatory drugs).

Decision rationale: The request is for the use of a medication in the NSAID class. The ODG state the following regarding this topic: Specific recommendations: Osteoarthritis (including knee and hip): Recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Acetaminophen may be considered for initial therapy for patients with mild to moderate pain, and in particular, for those with gastrointestinal, cardiovascular or renovascular risk factors. NSAIDs appear to be superior to acetaminophen, particularly for patients with moderate to severe pain. There is no evidence to recommend one drug in this class over another based on efficacy. In particular, there appears to be no difference between traditional NSAIDs and COX-2 NSAIDs in terms of pain relief. The main concern of selection is based on adverse effects. COX-2 NSAIDs have fewer GI side effects at the risk of increased cardiovascular side effects, although the FDA has concluded that long-term clinical trials are best interpreted to suggest that cardiovascular risk occurs with all NSAIDs and is a class effect (with naproxyn being the safest drug). There is no evidence of long-term effectiveness for pain or function. (Chen, 2008) (Laine, 2008) Back Pain: Acute low back pain & acute exacerbations of chronic pain: Recommended as a second-line treatment after acetaminophen. In general, there is conflicting to negative evidence that NSAIDs are more effective than acetaminophen for acute LBP. (van Tulder, 2006) (Hancock, 2007) For patients with acute low back pain with sciatica a recent Cochrane review (including three heterogeneous randomized controlled trials) found no differences in treatment with NSAIDs vs. placebo. In patients with axial low back pain this same review found that NSAIDs were not more effective than acetaminophen for acute low-back pain, and that acetaminophen had fewer side effects. (Roelofs-Cochrane, 2008) The addition of NSAIDs or spinal manipulative therapy does not appear to increase recovery in patients with acute low back pain over that received with acetaminophen treatment and advice from their physician. (Hancock, 2007) Back Pain: Chronic low back pain: Recommended as an option for short-term symptomatic relief. A Cochrane review of the literature on drug relief for low back pain (LBP) suggested that NSAIDs were no more effective than other drugs such as acetaminophen, narcotic analgesics, and muscle relaxants. The review also found that NSAIDs had more adverse effects than placebo and acetaminophen but fewer effects than muscle relaxants and narcotic analgesics. In addition, evidence from the review suggested that no one NSAID, including COX-2 inhibitors, was clearly more effective than another. (Roelofs-Cochrane, 2008) See also Anti-inflammatory medications. Neuropathic pain: There is inconsistent evidence for the use of these medications to treat long-term neuropathic pain, but they may be useful to treat breakthrough pain and mixed pain conditions such as osteoarthritis (and other nociceptive pain) in patients with neuropathic pain. (Namaka, 2004) (Gore, 2006) See NSAIDs, GI symptoms & cardiovascular risk; NSAIDs, hypertension and renal function; & Medications for acute pain (analgesics). Besides the above well-documented side effects of NSAIDs, there are other less well-known effects of NSAIDs, and the use of NSAIDs has been shown to possibly delay and hamper healing in all the soft tissues, including muscles, ligaments, tendons, and cartilage. (Maroon, 2006) The risks of NSAIDs in older patients, which include increased cardiovascular risk and gastrointestinal toxicity, may outweigh the benefits of these medications. (AGS, 2009) As stated above, acetaminophen would be considered first-line treatment for chronic pain. In this case, the continued use of an NSAID is not indicated. This is secondary to inadequate documentation of pain and functional improvement benefit seen. Also, the duration of use places the patient at risk for gastrointestinal and cardiovascular side-effects. In addition, it is known that use of NSAIDs delays the healing of soft tissue including ligaments, tendons, and cartilage. As such, the request is not medically necessary.

30 Lidocaine 5% (700 mg/patch): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: The request is for the use of a Lidoderm patch to aid in pain relief. The MTUS guidelines state that its use is indicated for post herpetic neuralgia after an initial trial of an anti-epileptic medication. Further research is needed to recommend use for chronic neuropathic disorders besides post-herpetic neuralgia. In this case, the patient does not have a diagnosis documented which would justify the use of Lidoderm patches. As such, the request is not medically necessary.

60 Orphenadrine citrate 100mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Muscle relaxants (for pain).

Decision rationale: The request is for the use of a muscle relaxant to aid in pain relief. The MTUS guidelines state that the use of a medication in this class is indicated as a second-line option for short-term treatment of acute exacerbations of low back pain. Muscle relaxants may be effective in reducing pain and muscle tension, which can increase mobility. However, in most LBP cases, they show no benefit beyond NSAIDs in pain improvement. Efficacy appears to diminish over time, and prolonged use may lead to dependence. (Homik, 2004) Due to inadequate documentation of a recent acute exacerbation and poor effectiveness for chronic long- term use, the request is not medically necessary.