

Case Number:	CM15-0069385		
Date Assigned:	04/17/2015	Date of Injury:	10/06/1998
Decision Date:	06/09/2015	UR Denial Date:	04/02/2015
Priority:	Standard	Application Received:	04/13/2015

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: New York

Certification(s)/Specialty: Anesthesiology

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 67 year old male who sustained an industrial injury on 10/6/1998. His diagnoses, and/or impressions, included lumbar radicular syndrome; discogenic syndrome; lumbar spondylosis; post-cervical laminectomy syndrome; and angioplasty. No current magnetic resonance imaging studies are noted. His treatments have included medication management. Recent progress notes of 10/2/2014 reported low back pain that radiated into the bilateral buttock, posterior thigh, right calf and right foot. He stated the pain is constant, moderate and associated with numbness and weakness; noting some relief with medications. The physician's requests for treatments were noted to include Percocet, Aciphex, bilateral lumbar transforaminal epidural steroid injections; Clonazepam; Neurontin; and Temazepam.

IMR ISSUES, DECISIONS AND RATIONALES

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

Percocet tab 10/625mg #60: 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 Opioids Page(s): 91-97. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Opioids.

Decision rationale: According to the CA MTUS and the ODG, Percocet (Oxycodone/Acetaminophen) is a short-acting opioid analgesic indicated for moderate to severe pain, and is used to manage both acute and chronic pain. The treatment of chronic pain with any opioid analgesic requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. A pain assessment should include current pain, intensity of pain after taking the opiate, and the duration of pain relief. In this case, there is no documentation of the medication's pain relief effectiveness, functional status, or response to ongoing opioid analgesic therapy. Medical necessity of the requested medication has not been established. Of note, discontinuation of an opioid analgesic should include a taper, to avoid withdrawal symptoms. The requested treatment with Percocet 10/325 mg is not medically necessary.

Acihex tab 20mg 30 with 5 refills: 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 PPIs Page(s): 68. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) PPIs.

Decision rationale: According to CA MTUS (2009), proton pump inhibitors, such as Aciphex (Rabeprazole), are recommended for patients taking NSAIDs with documented GI distress symptoms or specific GI risk factors. Risk factors include, age >65, history of peptic ulcer disease, GI bleeding, concurrent use of aspirin, corticosteroids, and/or anticoagulants or high-dose/multiple NSAIDs. According to the ODG, a trial of omeprazole or lansoprazole had been recommended before prescription Nexium therapy (before it went OTC). Other PPIs, such as Aciphex, should be second-line. In this case, there is no documentation indicating the patient has any GI symptoms or GI risk factors. It is unclear if this patient is currently taking an NSAID. Based on the available information provided for review, the medical necessity for Aciphex has not been established. The requested medication is not medically necessary.

Bilateral transforaminal I ESI at L4-L5: 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 EPSIs Page(s): 46.

Decision rationale: A selective nerve root block, or transforaminal epidural steroid injection (ESI), is a variation of the traditional midline ESI; the spinal nerve roots exit the spine laterally. Based on a patient's medical history, a physical exam, and MRI findings, often a specific

inflamed nerve root can be identified. According to the CA MTUS guidelines, criteria for ESI's include the following: radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electro-diagnostic testing; initially unresponsive to conservative treatment; and no more than two nerve root levels should be injected using transforaminal blocks. Repeat blocks should only be offered if there is at least 50-70% pain relief for six to eight weeks following previous injection, with a general recommendation of no more than 4 blocks per region per year. In this case, there is no documentation of objective findings of radicular pain in a dermatomal distribution that correlates with the targeted nerve root lesions. Medical necessity for the requested transforaminal ESI's has not been established. The requested injections are not medically necessary.

Clonazepam tab 1mg #15: 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 Benzodiazepines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Benzodiazepines.

Decision rationale: According to CA MTUS Guidelines, benzodiazepines are prescribed for anxiety. They are not recommended for long-term use for the treatment of chronic pain because long-term efficacy is unproven and there is a risk of dependency. Clonazepam (Klonopin) is a long-acting benzodiazepine, having anxiolytic, sedative, and hypnotic properties. Most guidelines recommend the use of Clonazepam for the treatment of anxiety disorders, and as an adjunct treatment for anxiety associated with major depression. Use of this medication is limited to four weeks. There are no guideline criteria that supports the long-term use of benzodiazepines. In this case, there was no documentation of the indication and duration of use. Medical necessity for the requested medication has not been established. The requested medication is not medically necessary.

Neurontin cap 400mg #60: 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 Anti-epilepsy drugs (AEDs) Page(s): 17-19. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) AEDs.

Decision rationale: According to the CA MTUS (2009) and ODG, Neurontin (Gabapentin) is an anti-epilepsy drug which has been considered a first-line treatment for neuropathic pain. The records documented that the patient has neuropathic pain related to his chronic low back condition. In this case, there was no documentation of subjective or objective findings consistent with functional improvement with Neurontin. Medical necessity for Neurontin has not been established. The requested medication is not medically necessary.

Temazepam cap 22.5mg #15: 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 Benzodiazepines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Benzodiazepines.

Decision rationale: Restoril (Temazepam) is an intermediate-acting 3-hydroxy hypnotic of the benzodiazepine class of psychoactive drugs. It is approved for the short-term treatment of insomnia. According to CA MTUS Guidelines, benzodiazepines are prescribed for anxiety. They are not recommended for long-term use for the treatment of chronic pain because long-term efficacy is unproven and there is a risk of dependency. There is no documentation provided indicating that the patient has a diagnosis of insomnia or indicating the duration of therapy with this medication. There are no guideline criteria that support the long-term use of benzodiazepines for sleep disturbances. Medical necessity for the requested medication has not been established. The requested medication is not medically necessary.