

Case Number:	CM15-0095316		
Date Assigned:	05/21/2015	Date of Injury:	05/31/2002
Decision Date:	06/29/2015	UR Denial Date:	04/20/2015
Priority:	Standard	Application Received:	05/18/2015

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 72 year old female, who sustained an industrial injury on 5/31/2002. The mechanism of injury was not noted. The injured worker was diagnosed as having lumbago with left sided neuropathy, sacroiliac joint and facet joint arthropathy, migraine headaches, reactive depression and anxiety, reactive insomnia, and recent fall with vertebral fracture. Treatment to date has included medications, lumbar epidural steroid injections, and urine toxicology. Currently, the injured worker complains of chronic lumbar pain, both axial and radicular, and significant muscle spasms throughout the lumbar spine. Pain was rated 6/10. It was noted that many of her medications were not authorized or modified, with recommendations for tapering. This was not done and she was documented as in danger of running out of medication or rebound pain. Denial of a lumbar epidural steroid injection was also disputed. She continued Ambien to improve sleep initiation and maintenance. Physical exam noted sciatic notch tenderness bilaterally, worse on left side, focal tenderness over the facet joints, positive facet provocation bilaterally, tenderness over the sacroiliac joints, with positive provocation test, painful and decreased range of motion, sensory deficits at L4, L5, and S1 dermatomes, motor weakness in the left lower extremity (4+/5 knee flexion and ankle dorsiflexion), and paraspinal muscle spasms throughout the lumbar spine. Her functional status remained very stable over the past months and she remained very functional and was able to perform activities of daily living. Medications included Fentanyl patch, Hydromorphone, Norco, Ambien, Nortriptyline, Xanax, Cymbalta, and Terocin 4% Lidocaine patch. Urine toxicology was performed and results were not noted. The treatment plan included continued medications and lumbar epidural steroid

injection. It was documented that she had benefit in the past from lumbar epidural steroid injections. Her pain was stable at 5-6/10 for several months, since at least 10/02/2014. Medications at that time also included Fentanyl patch, Hydromorphone, Norco, Ambien, Nortriptyline, Xanax, Cymbalta, and Terocin 4% Lidocaine patch.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ambien 10mg #60: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Pain (updated 04/06/15) Online Version.

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

Decision rationale: Ambien (Zolpidem) is a prescription short-acting non-benzodiazepine hypnotic, which is approved for the short-term (usually two to six weeks) treatment of insomnia and is rarely recommended for long-term use. It can be habit-forming, and may impair function and memory more than opioid analgesics, and may increase pain and depression over the long-term. The treatment of insomnia should be based on the etiology and pharmacological agents should only be used after careful evaluation of potential causes of sleep disturbance. There is no documentation provided indicating medical necessity for Ambien. The requested medication is not medically necessary.

Xanax 0.5 mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

Decision rationale: Alprazolam (Xanax) is a short-acting benzodiazepine drug having anxiolytic, sedative, and hypnotic properties. The medication is used in conjunction with antidepressants for the treatment of depression with anxiety, and panic attacks. Per California MTUS Guidelines, benzodiazepines 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. Most guidelines limit use of Xanax to four weeks. Medical necessity of the requested medication has not been established. The requested medication is not medically necessary.

Terocin 4% Lidocaine #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 105, 111-113.

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

Decision rationale: According to the California MTUS Guidelines, topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied topically to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control including, for example, NSAIDs, opioids, capsaicin, local anesthetics or antidepressants. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. In this case there is no documentation provided necessitating Terocin. This medication contains methyl salicylate, capsaicin, menthol, and lidocaine. MTUS states that capsaicin is recommended only as an option in patients who have not responded or are intolerant to other treatments. There is no documentation of intolerance to other previous medications. Medical necessity for the requested topical medication has not been established. The requested treatment is not medically necessary.

Norco 10/325mg #240: Upheld

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

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 MTUS and ODG, Norco 10/325 mg (Hydrocodone/Acetaminophen) is a short-acting opioid analgesic indicated for moderate to moderately 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 medication is not medically necessary.

Lumbar Epidural Steroid Injection: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 46.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ESIs Page(s): 46.

Decision rationale: Epidural steroid injections (ESIs) are recommended as an option for treatment of radicular pain (defined as pain in a dermatomal distribution with corroborative findings of radiculopathy). Most current guidelines recommend no more than 2 ESI injections. Research has shown that, on average, less than two injections are required for a successful ESI outcome. ESIs can offer short-term pain relief and use should be in conjunction with other rehab efforts. The purpose of ESIs is to reduce pain and inflammation, restoring range of motion and thereby facilitating progress in more active treatment programs, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit. The American Academy of Neurology recently concluded that epidural steroid injections may lead to an improvement in radicular lumbosacral pain between 2 and 6 weeks following the injection, but they do not affect impairment of function or the need for surgery and do not provide long-term pain relief beyond 3 months. CA MTUS guidelines state radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electro-diagnostic testing. The patient must be initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). In this case, the patient received a previous lumbar ESI with improvement of low back pain, but the duration of relief was not documented. In addition, the lumbar level for the requested ESI is not specified. Medical necessity for the requested service has not been established. The requested lumbar epidural steroid injection is not medically necessary.