

<b>Case Number:</b>	CM15-0129153		
<b>Date Assigned:</b>	07/15/2015	<b>Date of Injury:</b>	03/26/2008
<b>Decision Date:</b>	10/15/2015	<b>UR Denial Date:</b>	06/26/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/02/2015

### 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: Texas, California

Certification(s)/Specialty: Family Practice

### 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 64 year old male, who sustained an industrial injury on 3/26/08. The injured worker has complaints of pain in both knees. The documentation noted that the injured workers bilateral knees are painful as a direct result of the patient falling consistently once or twice a month when his legs give out because of his lumbar spine disability as well as his awkward antalgic gait. The documentation noted that the injured worker complains of pain in his lower back radiating down to both lower extremities. The posterior lumbar musculature reveals tenderness to palpation bilaterally with increased muscle rigidity with numerous trigger points that are palpable and tender throughout the lumbar paraspinal muscles. There is decreased range of motion with obvious muscle guarding. The diagnoses have included intervertebral disc disorder with myelopathy, lumbar region. Treatment to date has included corticosteroid injection to his left knee; lumbar spinal cord stimulator; trigger point injections; duragesic; Percocet; Flexeril and lumbar sacral orthosis back support. The request was for Neurontin 600mg #120 with 2 refills; Percocet 10/325mg #60; duragesic patches 75mg #15; restoril 30mg #30 with 5 refills; Flexeril 10mg #60 with 5 refills; lumbo-sacral orthosis back brace and unknown quantity and duration of continue with self-directed physical therapy as well as participate in aqua therapy program at his local gym. The patient has had history of lumbar radiculopathy with discopathy, right femoral neck fracture and ORIF in 2008, right rotator cuff repair in 2008; right shoulder adhesive capsulitis in 2009; decompression of the left peroneal nerve in 9/9/2011; lumbar fusion on 7/27/2012 and implantation of spinal cord stimulator. The medication list include Neurontin, Percocet, Flexeril, Duragesic patch, and Restoril. The patient has had MRI of the lumbar spine in

2011 that revealed disc protrusions, foraminal narrowing, and CT scan revealed post-surgical changes; EMG of lower extremity in 2011 that revealed lumbar radiculopathy. The patient had received an unspecified number of PT visits for this injury. The patient has had UDS that was consistent for opioid and benzodiazepine on 9/14/15. Per the note dated 8/14/15 the patient had complaints of low back pain with radiculopathy at 7/10. Physical examination of the lumbar spine revealed tenderness on palpation, trigger points, limited range of motion, muscle rigidity, positive SLR, decreased sensation in lower extremity and 4/5 strength. Patient had received trigger point injections and corticosteroid injection in left knee for this injury. A recent detailed psychological/ psychiatric evaluation note was not specified in the records provided.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Neurontin 600mg #120 with 2 refills:** Overturned

**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): Anti-epilepsy drugs (AEDs).

**Decision rationale:** According to the CA MTUS Chronic pain guidelines regarding Neurontin/gabapentin, has been shown to be effective for treatment of diabetic painful neuropathy and post herpetic neuralgia and has been considered as a first-line treatment for neuropathic pain. Spinal cord injury: Recommended as a trial for chronic neuropathic pain Lumbar spinal stenosis: Recommended as a trial, with statistically significant improvement found in walking distance, pain with movement, and sensory deficit This medication appears to be effective in reducing abnormal hypersensitivity (allodynia and hyperalgesia), to have anti-anxiety effects, and may be beneficial as a sleep aid. The diagnoses have included intervertebral disc disorder with myelopathy, lumbar region. The patient has had history of lumbar radiculopathy with discopathy, right femoral neck fracture and ORIF in 2008, right rotator cuff repair on in 2008; right shoulder adhesive capsulitis in 2009; decompression of the left peroneal nerve in 9/9/2011; lumbar fusion on 7/27/2012 and implantation of spinal cord stimulator. The patient has had MRI of the lumbar spine in 2011 that revealed disc protrusions, foraminal narrowing, and CT scan revealed post-surgical changes; EMG of lower extremity in 2011 that revealed lumbar radiculopathy. Per the note dated 8/14/15 the patient had complaints of low back pain with radiculopathy at 7/10. Physical examination of the lumbar spine revealed tenderness on palpation, trigger points, limited range of motion, muscle rigidity, positive SLR, decreased sensation in lower extremity and 4/5 strength. The patient has chronic pain with a neuropathic component. The patient has abnormal objective findings that are consistent with the patient's symptoms. Anticonvulsants or anti-epileptics like gabapentin / Neurontin are medically appropriate and necessary in this patient. The cited guidelines support the use of Neurontin 600mg #120 with 2 refills in patients with this clinical situation therefore the request is deemed medically necessary.

**Percocet 10/325mg #60:** Overturned

**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:** Percocet contains acetaminophen and oxycodone which is an opioid analgesic. According to CA MTUS guidelines cited below, a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Before initiating therapy, the patient should set goals, and the continued use of opioids should be contingent on meeting these goals. Other criteria for ongoing management of opioids are: The lowest possible dose should be prescribed to improve pain and function. Continuing review of the overall situation with regard to non-opioid means of pain control. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. In addition according to the cited guidelines Short-acting opioids: also known as normal-release or immediate-release opioids are seen as an effective method in controlling chronic pain. They are often used for intermittent or breakthrough pain. The diagnoses have included intervertebral disc disorder with myelopathy, lumbar region. The patient has had history of lumbar radiculopathy with discopathy, right femoral neck fracture and ORIF in 2008, right rotator cuff repair on in 2008; right shoulder adhesive capsulitis in 2009; decompression of the left peroneal nerve in 9/9/2011; lumbar fusion on 7/27/2012 and implantation of spinal cord stimulator. The patient has had MRI of the lumbar spine in 2011 that revealed disc protrusions, foraminal narrowing, and CT scan revealed post-surgical changes; EMG of lower extremity in 2011 that revealed lumbar radiculopathy. Per the note dated 8/14/15 the patient had complaints of low back pain with radiculopathy at 7/10. Physical examination of the lumbar spine revealed tenderness on palpation, trigger points, limited range of motion, muscle rigidity, positive SLR, decreased sensation in lower extremity and 4/5 strength. The patient has chronic pain with significant abnormal objective findings. The patient has had UDS that was consistent for opioid and benzodiazepine on 9/14/15. There is no evidence of aberrant behavior. This medication is deemed medically appropriate and necessary to treat any exacerbations of the pain on an as needed/ prn basis. The medication Percocet 10/325mg #60 is medically necessary and appropriate in this patient

**Duragesic patches 75mg #15:** Overturned

**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): Duragesic (fentanyl transdermal system), Fentanyl, Opioids, criteria for use.

**Decision rationale:** Criteria for ongoing management of opioids are: The lowest possible dose should be prescribed to improve pain and function. Continuing review of overall situation with regard to non-opioid means of pain control. Ongoing review and documentation of pain relief, functional status appropriate medication use, and side effects. The diagnoses have included intervertebral disc disorder with myelopathy, lumbar region. The patient has had history of lumbar radiculopathy with discopathy, right femoral neck fracture and ORIF in 2008, right rotator cuff repair on in 2008; right shoulder adhesive capsulitis in 2009; decompression of the left peroneal nerve in 9/9/2011; lumbar fusion on 7/27/2012 and implantation of spinal cord stimulator. The patient has had MRI of the lumbar spine in 2011 that revealed disc protrusions, foraminal narrowing, and CT scan revealed post-surgical changes; EMG of lower extremity in 2011 that revealed lumbar radiculopathy. Per the note dated 8/14/15 the patient had complaints of low back pain with radiculopathy at 7/10. Physical examination of the lumbar spine revealed tenderness on palpation, trigger points, limited range of motion, muscle rigidity, positive SLR,

decreased sensation in lower extremity and 4/5 strength. The patient has chronic pain with significant abnormal objective findings. He has also had multiple major surgeries. The patient has had UDS that was consistent for opioid and benzodiazepine on 9/14/15. There is no evidence of aberrant drug behavior. The request for Duragesic patches 75mg #15 is medically necessary and appropriate for this patient at this time.

**Restoril 30mg #30 with 5 refills:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain, Insomnia treatment, Benzodiazepines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Benzodiazepines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (updated 09/08/15) Benzodiazepines.

**Decision rationale:** According to MTUS guidelines Benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. Their range of actions includes sedative/hypnotic, anxiolytic, anticonvulsant, and muscle relaxant. Chronic benzodiazepines are the treatment of choice in very few conditions. Tolerance to hypnotic effects develops rapidly. Tolerance to anxiolytic effects occurs within months and long-term use may actually increase anxiety. Per the cited guidelines, Benzodiazepines are a major cause of overdose, particularly as they act synergistically with other drugs such as opioids (mixed overdoses are often a cause of fatalities). Tolerance to anticonvulsant and muscle relaxant effects occurs within weeks. Tolerance to lethal effects does not occur and a maintenance dose may approach a lethal dose as the therapeutic index increases. The best prevention for substance use disorders due to benzodiazepines is careful prescribing. (Baillargeon, 2003) (Ashton, 2005) (Dickinson, 2009) (Lader, 2009) Adults who use hypnotics, including benzodiazepines, have a greater than 3-fold increased risk for early death, according to results of a large matched cohort survival analysis. The risks associated with hypnotics outweigh any benefits of hypnotics, according to the authors. In 2010, hypnotics may have been associated with 320,000 to 507,000 excess deaths in the U.S. alone. The AGS updated Beers criteria for inappropriate medication use includes benzodiazepines. (AGS, 2012) Use of benzodiazepines to treat insomnia or anxiety may increase the risk for Alzheimer's disease (AD) A recent detailed psychological / psychiatry evaluation note was not specified in the records provided. As mentioned above, prolonged use of anxiolytic may lead to dependence and does not alter stressors or the individual's coping mechanisms. The cited guideline recommends that if anti-anxiety medication is needed for a longer time, appropriate referral needs to be considered. The rationale for 5 refills of a benzodiazepine without a re-evaluation was not specified in the records provided. The medical necessity of the request for Restoril 30mg #30 with 5 refills, as prescribed, is not fully established in this patient given the records provided and the guidelines cited.

**Flexeril 10mg #60 with 5 refills:** Overturned

**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): Cyclobenzaprine (Flexeril).

**Decision rationale:** According to CA MTUS guidelines cited below, Recommended as an option, using a short course of therapy. Cyclobenzaprine (Flexeril) is more effective than placebo in the management of back pain. The diagnoses have included intervertebral disc disorder with myelopathy, lumbar region. The patient has had history of lumbar radiculopathy with discopathy, right femoral neck fracture and ORIF in 2008, right rotator cuff repair on in 2008; right shoulder adhesive capsulitis in 2009; decompression of the left peroneal nerve in 9/9/2011; lumbar fusion on 7/27/2012 and implantation of spinal cord stimulator. The patient has had MRI of the lumbar spine in 2011 that revealed disc protrusions, foraminal narrowing, and CT scan revealed post-surgical changes; EMG of lower extremity in 2011 that revealed lumbar radiculopathy. Per the note dated 8/14/15 the patient had complaints of low back pain with radiculopathy at 7/10. Physical examination of the lumbar spine revealed tenderness on palpation, trigger points, limited range of motion, muscle rigidity, positive SLR, decreased sensation in lower extremity and 4/5 strength. The patient has evidence of muscle rigidity on objective examination. The patient also has chronic conditions with abnormal objective findings. These conditions are prone to intermittent exacerbations. Therefore with this, it is deemed that, the use of the muscle relaxant Flexeril 10mg #60 with 5 refills is medically appropriate and necessary in this patient.

**Unknown quantity and duration of continue with self-directed physical therapy as well as participate in aqua therapy program at his local gym:** 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): Aquatic therapy, Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back (updated 09/22/15)Gym memberships.

**Decision rationale:** The guidelines cited below state, "allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home physical medicine." Per the ODG guidelines gym membership is not recommended as a medical prescription unless a documented home exercise program with periodic assessment and revision has not been effective and there is a need for equipment. Patient has received an unspecified number of PT visits for this injury. The requested additional visits in addition to the previously certified PT sessions are more than recommended by the cited criteria. There was no evidence of ongoing significant progressive functional improvement from the previous PT visits that is documented in the records provided. Previous PT visits notes were not specified in the records provided. There was no objective documented evidence of any significant functional deficits that could be benefitted with additional PT. Evidence of a contraindication to land based therapy was not specified in the records provided. A medical need for exercise equipment was not specified in the records provided. Any evidence of extreme obesity (that would require aquatic or pool therapy) was not specified in the records provided. Per the guidelines cited, "Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels." A valid rationale as to why remaining rehabilitation cannot be accomplished in the context of an independent exercise program is not specified in the records provided. The medical necessity of the request for Unknown quantity and duration of continue with self-directed physical therapy as well as participate in aqua therapy program at his local gym is not fully established for this patient.

**LSO back support:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004.

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Initial Assessment. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (updated 09/08/15) Lumbar supports.

**Decision rationale:** Per the ACOEM guidelines cited below, there is no evidence for the effectiveness of lumbar supports in preventing back pain in industry. In addition per the ODG cited below regarding lumbar supports/brace, Prevention: Not recommended for prevention. There is strong and consistent evidence that lumbar supports were not effective in preventing neck and back pain Treatment: Recommended as an option for compression fractures and specific treatment of spondylolisthesis, documented instability, and for treatment of nonspecific LBP (very low-quality evidence, but may be a conservative option). Under study for post-operative use; see Back brace, post-operative (fusion). Patient has received an unspecified number of PT visits for this injury. Response to prior conservative therapy was not specified in the records provided. Prior conservative therapy notes were not specified in the records provided. Any evidence of diminished effectiveness of medications or intolerance to medications was not specified in the records provided. There is no evidence of instability, spondylolisthesis, lumbar fracture or recent lumbar surgery. Any surgery or procedure note related to this injury was not specified in the records provided. The medical necessity, of LSO back support quantity is not fully established.