

Case Number:	CM13-0015776		
Date Assigned:	01/03/2014	Date of Injury:	11/11/2009
Decision Date:	03/18/2014	UR Denial Date:	07/30/2013
Priority:	Standard	Application Received:	08/23/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Pain Management, has a subspecialty in Disability Evaluation and is licensed to practice in California. 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 patient is a 32 year-old female who incurred an industrial injury on 11/11/2009. At that time, while employed as an occupational therapist at [REDACTED], she was assisting a patient who fell onto her left arm and as a result injured her back. At the time the patient fell on her, she began having excruciating pain which extended upward into the thoracic region. Her lower lumbar pain is now constant in duration. The upper back pain is intermittent. She describes the character of the pain as aching, sharp, and stabbing. Her pain is worse with sitting, standing, lifting, and bending. It is somewhat relieved with rest, heat, and cold. All of her daily activities are limited secondary to pain, in particular her ability to perform household work and care for herself. As a result of her injury, she is unable to lift, bend, stoop, or twist, as well as sit or stand for any extended period of time. In the most recent medical report for office visit (OV) on 6/18/13 it was noted that the patient reports ongoing pain to upper and mid-low back of sharp, achy and stabbing nature. Patient reports all activities of daily living (ADL's) are affected by pain, and pain has worsened since last visit. Current RX includes: Dilaudid 4mg, Cymbalta 60mg and Lidoderm patches 5%. PE: 65 inches, 148 pounds, NAD. Gait is markedly antalgic, as are heel and toe ambulation. There is marked tenderness over the left sacroiliac Joint and over the thoracic and Lumbar paraspinal muscles, as well as in the right traps and rhomboids. Cervical range of motion (ROM); flexion 40 degrees, extension 40 degrees, left lateral flex 25 degrees, right lateral flex 5 degrees, left lateral rotation 90 degrees, right lateral rot 20 degrees. Lumbar ROM: flex 80 degrees, extension 10 degrees, left lateral flex 15 degrees, right fat flex 15 degrees, bilateral lateral rotations 20 degrees each. Motor power is within normal limits (WNL), all groups tested are 5/5 strength. Sensation is intact to light touch globally, straight leg raising (SLR) are negative bilaterally, Faber test is positive on the left and negative on the right. The request is for outpatient return office visit for injection to left sacroiliac, three (3) additional

trigger point injections for left sacroiliac and purchase of Dilaudid 4mg quantity ninety (90), Cymbalta 60mg quantity thirty(30), and Lidoderm patch 5%, quantity ninety(90).

IMR ISSUES, DECISIONS AND RATIONALES

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

Outpatient return office visit for injection to left sacroiliac: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) -TWC-Hip & Pelvis (Acute & Chronic)(updated 12/09/13) Sacroiliac Joint Injections

Decision rationale: Sacroiliac joint injections are not recommended for treatment of acute low back pain including low back pain thought to be sacroiliac joint related; sub acute or chronic non-specific low back pain, including pain attributed to the sacroiliac joints, but without evidence of inflammatory sacroiliitis (rheumatologic disease); or any radicular pain syndrome. According to Blue Cross blue Shield of North Carolina Guidelines, Medical Evidence regarding Sacroiliac Joint Arthrography and Injection indicates it is not recommended in the following situations There is limited prospective or controlled evidence for sacroiliac joint arthrography or injection therapy. Trials are needed that compare specific procedures in defined populations to placebo and to alternative treatments. Case series are inadequate evidence due to the variable natural history of back pain, the presence of confounders of outcome, and the potential for a placebo effect. In general, the literature regarding injection therapy on joints in the back is of poor quality. The current evidence on sacroiliac joint arthrography and injections is insufficient to permit conclusions regarding the effect of these procedures on health outcomes. Therefore, these techniques are not recommended at this time The treating provider indicated that previous Sacro-iliac joint injections and trigger point injections have helped to control her pain with no injection of percentage pain reliever. ODG guideline stipulates that If steroids are injected during the initial injection, the duration of pain relief should be at least 6 weeks with at least > 70% pain relief recorded for this period and in the treatment or therapeutic phase (after the stabilization is completed), the suggested frequency for repeat blocks is 2 months or longer between each injection, provided that at least >70% pain relief is obtained for 6 weeks.

Three (3) additional trigger point injections (TPIs) for left sacroiliac: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Trigger Points injections Page(s): 122. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) -TWC-PAIN(Chronic)(Updated 3/10/2014)-Trigger Points Injections (TPIs).

Decision rationale: Regarding trigger point Injections, MTUS criteria for trigger point Injections include chronic low back or neck pain with myofascial pain syndrome with circumscribed trigger points with evidence upon palpation of a twitch response as well as referred pain; symptoms for more than three months; medical management therapies have failed; radiculopathy is not present; and no more than 3-4 injections per session. Additionally, repeat injections are not recommended unless greater than 50% pain relief has been obtained for six weeks following previous Injections, including functional improvement. The treating physician indicated that previous trigger point injections were beneficial but did not specify how long the pain relieves lasted and any functional improvement as a result of trigger point injections. Therefore the request for Trigger point injections is not medically necessary.

Dilaudid 4mg quantity ninety (90): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Hydromorphone Page(s): 93. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) -TWC-Pain (Chronic)(Updated 3/10/2014) Opioids for chronic pain.

Decision rationale: With respect to prescription for Dilaudid 4mg quantity ninety (90), while long-term opioid therapy may benefit some patients with severe suffering that has been refractory to other medical and psychological treatments, it is not generally effective in achieving the original goals of complete pain relief and functional restoration. Propensity for side effects significantly increases. Additionally, It is currently suggested that of the patients that proceed to long-term opioid use (90 days or more); two-thirds continue opioids for years later, creating life-long therapy. And addiction. Therefore the request for Dilaudid is not medically necessary, and should be weaned off as soon as possible and a consideration or psyche evaluation for any psychological component of the chronic back pain.

Cymbalta 60mg quantity thirty (30): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cymbalta Page(s): 15 -16. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) -TWC-Pain (Chronic)(Updated 3/10/2014)-Duloxetine (Cymbalta®)

Decision rationale: With respect to Cymbalta (Duloxetine), CA-MTUS guidelines states that Duloxetine is recommended as a first-line option for diabetic neuropathy. No high quality evidence is reported to support the use of duloxetine for lumbar radiculopathy. The FDA approved duloxetine HCl delayed-release capsules (Cymbalta; Eli Lilly and Co) for the once-daily treatment of chronic musculoskeletal pain. Used off-label for neuropathic pain and radiculopathy. Duloxetine is recommended as a first-line option for diabetic neuropathy. (Dworkin, 2007). More studies are needed to determine the efficacy of duloxetine for other types

of neuropathic pain. Tricyclics are generally considered a first-line agent unless they are ineffective; poorly tolerated, or contraindicated. Analgesia generally occurs within a few days to a week, whereas antidepressant effect takes longer to occur. Assessment of treatment efficacy should include not only pain outcomes, but also an evaluation of function, changes in use of other analgesic medication, sleep quality and duration, and psychological assessment. Since there is no documentation of trial of tricyclics, the request for 60 Cymbalta 20mg is not medically necessary

Lidoderm patch 5% quantity ninety (90): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 112. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) -TWC-Pain (Chronic) (Updated 3/10/2014) Treatment-Topical Analgesics.

Decision rationale: Regarding the request for Lidoderm Patch, it is recommended for treatment of Neuropathic pain as well as localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). There is no documentation that this recommendation was followed. Therefore the request for Lidoderm patch is not medically necessary.