

<b>Case Number:</b>	CM13-0054239		
<b>Date Assigned:</b>	01/15/2014	<b>Date of Injury:</b>	03/24/2008
<b>Decision Date:</b>	04/11/2014	<b>UR Denial Date:</b>	11/11/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/19/2013

### 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. The expert reviewer is Board Certified in Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in Georgia. 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/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 claimant is a 51 year old male presenting with low back pain following a work related injury on March 24, 2013. The claimant has a history of multiple injuries including fusion of L5-S1, which failed to provide relief. The claimant reports that medications do offer some relief with a pain rating of 4-5/10. The physical exam was significant for positive straight-leg raise, decreased sensation to light touch in the feet bilaterally, weakness in the lower extremities bilaterally. The claimant was evaluated by a surgeon and repeat surgery involving anterior fusion was recommended. The claimant was diagnosed with lumbar radiculopathy, depression, failed back surgery syndrome with non-union, diabetes mellitus with peripheral neuropathy, chronic pain syndrome and opioid dependency.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**SPINAL CORD STIMULATOR TRIAL:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Complex Regional Pain Page(s): 32.

**Decision rationale:** According to the California MTUS Guidelines, spinal cord stimulators are recommended only for selected patients in cases when less invasive procedures have failed or are contraindicated, for specific conditions, and following a successful temporary trial. Although there is limited evidence in favor of Spinal Cord Stimulators (SCS) for Failed Back Surgery Syndrome (FBSS) and Complex Regional Pain Syndrome (CRPS) Type I, more trials are needed to confirm whether SCS is an effective treatment for certain types of chronic pain. The claimant was evaluated by a surgeon and a repeat surgery with anterior fusion was recommended; therefore, the requested procedure is not medically necessary.

**A PSYCHOLOGICAL EVALUATION FOR A SPINAL CORD STIMULATOR TRIAL:**  
Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Psychological evaluations Page(s): 100-101.

**Decision rationale:** Psychological evaluations are generally accepted, well-established, diagnostic procedures not only with selected use in pain problems, but also with a more widespread use in chronic pain populations. Diagnostic evaluations should distinguish between conditions that are preexisting, aggravated by the current injury or work related. Psychosocial evaluations should determine if further psychosocial interventions are indicated. The interpretations of the evaluation should provide clinicians with a better understanding of the patient in their social environment, thus allowing for a more effective rehabilitation. The psychological evaluation was ordered for spinal cord stimulator. Given that, the stimulator is not medically necessary, the requested service is also not medically necessary.

**VICODIN, #120:** 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): 79.

**Decision rationale:** According to the California MTUS Guidelines, the weaning of opioids is recommended if (a) there are no overall improvement in function, unless there are extenuating circumstances (b) continuing pain with evidence of intolerable adverse effects (c) decrease in functioning (d) resolution of pain (e) if serious non-adherence is occurring (f) the patient requests discontinuing. The claimant's medical records did not document that there was an overall improvement in function or a return to work with previous opioid therapy. In fact, the medical records note that the claimant was permanent and stationary. The claimant has a long-term use with this medication and there was a lack of improved function with this opioid; therefore the requested medication is not medically necessary.

**ZANAFLEX, #90:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63-66.

**Decision rationale:** According to the California MTUS Guidelines, Tizanidine (Zanaflex<sup>®</sup>, generic available) is a centrally acting alpha2-adrenergic agonist that is FDA approved for management of spasticity. It is also used for low back pain, but only eight (8) studies have demonstrated efficacy for this unlabeled use. One study (conducted only in females) demonstrated a significant decrease in pain associated with chronic myofascial pain syndrome and the authors recommended its use as a first line option to treat myofascial pain. It may also provide benefit as an adjunct treatment for fibromyalgia. The recommended dosing is 4mg with a max dose of 36mg per day. The medical records indicate that the Zanaflex was prescribed for back pain. The California MTUS guidelines recommend short-term use for myofascial pain or fibromyalgia; therefore, the claim is not medically necessary.

**CELEBREX 20MG, #30:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67.

**Decision rationale:** Celebrex is a Cox-2 inhibitor nonsteroidal anti-inflammatory medication. According to the California MTUS Guidelines, NSAIDs are recommended for osteoarthritis at the lowest dose for the shortest period in patients with moderate to severe pain so to prevent or lower the risk of complications associate with cardiovascular disease and gastrointestinal distress. The medical records do no document the length of time he has been on Celebrex. Additionally, a diagnosis of osteoarthritis has not been documented in the medical records. Finally, there is no documentation of gastrointestinal risk requiring a cox-2 inhibitor anti-inflammatory medication; therefore, the request is not medically necessary.

**LIDODERM 5%, #30:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112.

**Decision rationale:** According to the California MTUS Guidelines topical analgesics are recommended for localized peripheral pain after there has been evidence of a trial and failure of

first-line therapy (anti-depressants or AED). Only FDA-approved products are currently recommended. Topical Analgesics are not recommended for non-neuropathic pain. The claimant was not diagnosed with neuropathic pain and there is no documentation of physical findings or diagnostic imaging confirming the diagnosis. The claimant was diagnosed with multiple issues related to chronic pain. Therefore the request is not medically necessary.

**CMP CREAM, 120GM:** 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 Topical Analgesics Page(s): 111-112.

**Decision rationale:** CMP cream is a combination of Ketoprofen, Cyclobenzaprine and Lidocaine mixture. According to the California MTUS guidelines topical analgesics that are largely experimental in use with a few randomized controlled trials to determine efficacy or safety. Any compounded product that contains at least one drug or drug class that is not recommended, is not recommended. Additionally, Ketoprofen, which is a topical NSAID, is indicated for Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment. It is also recommended for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDs for treatment of pain associated with the spine, hip or shoulder; therefore, the compounded topical cream is not medically necessary.