

Case Number:	CM14-0142695		
Date Assigned:	09/24/2014	Date of Injury:	01/21/1998
Decision Date:	11/03/2014	UR Denial Date:	08/05/2014
Priority:	Standard	Application Received:	09/02/2014

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 Orthopedic Spine Surgeon and is licensed to practice in Texas. 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 injured worker is a 57-year-old male who reported an injury on 01/21/1998 due to an unknown mechanism of injury. The injured worker reportedly sustained an injury to his cervical and lumbar spine. The injured worker's treatment history included surgical intervention, medications, and physical therapy. The injured worker was monitored for aberrant behavior with urine drug screens. The injured worker was evaluated on 09/25/2014. The injured worker's medications were reported to be Kadian, Cymbalta, Zanaflex, and Norco. It was noted that the injured worker's Idrasil has been providing 50% pain relief. Physical findings included restricted range of motion of the cervical spine and lumbar spine. The injured worker had 5-/5 motor strength of the right upper extremity with decreased grip strength on the right when compared to the left. The injured worker's diagnoses included lumbar plexus lesion, chronic pain syndrome, postlaminectomy syndrome, radiculitis, postlaminectomy syndrome (cervical), radiculitis, opioid dependence, constipation, and myalgia. A request was for an implantation of a percutaneous peripheral neurostimulator and a refill of medications. No Request for Authorization form was submitted to support the request.

IMR ISSUES, DECISIONS AND RATIONALES

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

Implantation of percutaneous peripheral neurostimulator: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation J Clin Neurosci. 2007 March 14. Peripheral

nerve stimulation for the treatment of chronic pain. Mobbs RJ, Nair S. Blum P, Department of Neurosurgery, Institute of Neurological Sciences, The Prince of Wales Hospital; Neuromodulation. 2013, April 11. Peripheral Nerve Field Stimulation for the Management of Localized Chronic Intractable Pain, Results from a Randomized Controlled Study

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Percutaneous electrical nerve stimulation (PENS) Page(s): 97.

Decision rationale: California Medical Treatment Utilization Schedule recommends percutaneous electrical nerve stimulation on a trial basis as an adjunctive treatment to a Functional Restoration Program. The clinical documentation submitted for review does indicate that the injured worker has failed to respond to several treatment modalities, including surgical intervention, physical therapy, medications, and activity modifications. The clinical documentation submitted for review does indicate that physical therapy is part of the injured worker's treatment plan. Therefore, an adjunctive treatment, such as percutaneous peripheral neurostimulator would be indicated in this clinical situation. However, there is no documentation that the injured worker has undergone a trial that produced significant functional benefit or pain relief. In the absence of this information, the request for Implantation of Percutaneous Peripheral Neurostimulator is not medically necessary and appropriate.

Cymbalta 30mg #60 with 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for chronic pain and Anti-depressants Page(s): 60 and 13.

Decision rationale: California Medical Treatment Utilization Schedule recommends antidepressants as first line medications in the management of chronic pain. However, California Medical Treatment Utilization Schedule recommends the continued use of medications in the management of chronic pain be supported by functional benefit and pain relief. The clinical documentation submitted for review does not provide any evidence of significant functional benefit resulting from the use of Cymbalta. Additionally, a quantitative assessment of pain relief resulting from the use of Cymbalta is not reported. Furthermore, the request as it is submitted does not clearly provide a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the request for Cymbalta 30mg #60 with 1 refill is not medically necessary and appropriate.

Zanaflex 4mg #90 with 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), TWC Pain Procedure Summary

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63.

Decision rationale: California Medical Treatment Utilization Schedule does not recommend the use of muscle relaxants in the management of chronic pain. California Medical Treatment Utilization Schedule recommends that use of muscle relaxants be limited to 2 to 3 weeks for acute exacerbations of chronic pain. The clinical documentation does not indicate that the injured worker is undergoing an acute exacerbation of chronic pain and requires the use of a muscle relaxant. Additionally, the injured worker has been on this medication for a duration to exceed guideline recommendations. Therefore, continued use would not be supported. Furthermore, the request as it is submitted does not clearly identify a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the request for Zanaflex 4mg #90 with 1 refill is not medically necessary and appropriate.

Idrasil 25mg #60 with 3 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cannabinoids. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), TWC Pain Procedure Summary

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cannabinoids Page(s): 28.

Decision rationale: California Medical Treatment Utilization Schedule does not recommend the use of cannabinoids, as there is little scientific data to support the efficacy and safety of the long term use of this type of medication for medical purposes. There are no exceptional factors noted to support extending treatment beyond guideline recommendations. Therefore, continued use of this medication would not be supported. Furthermore, the request as it is submitted does not clearly identify a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the request for Idrasil 25mg #60 with 3 refills is not medically necessary and appropriate.