

<b>Case Number:</b>	CM14-0155208		
<b>Date Assigned:</b>	09/25/2014	<b>Date of Injury:</b>	01/18/2011
<b>Decision Date:</b>	10/27/2014	<b>UR Denial Date:</b>	08/27/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/23/2014

### 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 Physical Medicine and Rehabilitation 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 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 patient is a 45-year-old male who has submitted a claim for lumbago, sciatic, degenerated lumbar/lumbosacral intervertebral disc, lumbosacral spondylosis without myelopathy, anxiety and spasm of muscle associated with an industrial injury date of January 18, 2011. Medical records from 2013 through 2014 were reviewed, which showed that the patient complained of a chronic, severe intractable back and lower extremity pain. He also has chronic anxiety, depression and insomnia. Examination revealed tenderness at the lumbar paraspinals, tremors of both legs, limited lumbar ROMs, positive SLR bilaterally, and numbness and weakness in the LLE with decreased DTR at the left ankle. An MRI dated February 1, 2011 revealed: "Mild degenerative change at L4-5 with mild bulge, disc space narrowing an posterior element degenerative change that does result in borderline canal size and mild neuroforaminal narrowing. Mild degenerative change at L5-S1 is best-seen sagittally including mild bulge, disc space narrowing, and mild posterior element degenerative change that does not result in spinal stenosis though does result in mild right greater than left neuroforaminal narrowing." EMG/NCV of the LLE dated July 27, 2011 revealed: "Studies are normal. There is no evidence at this time of acute or chronic lumbosacral radiculopathy or other neuropathic process." Treatment to date has included physical therapy, medications, epidurals, left L4-5 hemilaminotomy, medial facetectomy, lateral recess decompression, left L4-5 microdiscectomy, microscopic assisted dissection and METRX access system on 7/9/13. He also had medial branch blocks at L3, L4 and L5 bilaterally in November and obtained 75% relief from those injections. There was no trial of SNRI or TCAs to date. Utilization review from August 27, 2014 denied the request for Spinal cord stimular trial, Ondansetron 8mg #30 no refills, and Oxycodone HCL 20mg #180 no refills. The request for spinal cord stimulator was denied because the patient has not yet failed use of SNRI and TCA antidepressants and subsequent RFA procedures. The request for

ondansetron was denied because the records do not establish that the patient presents with nausea and vomiting secondary to chemotherapy and radiation treatment or that the medication will be used postoperatively. The request for oxycodone was denied because the records do not establish any measurable functional improvement or a return to work specifically as a result of the use of opioid medications.

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

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

**Spinal cord stimular trial:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines (SCS) Spinal cord stimulators Page(s): 307.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines SPINAL CORD STIMULATORS Page(s): 105-107.

**Decision rationale:** According to pages 105 to 107 of the CA MTUS Chronic Pain Medical Treatment Guidelines, spinal cord stimulators are recommended only for cases when less invasive procedures have failed or are contraindicated. Indications for stimulator implantation include: failed back syndrome; Complex Regional Pain Syndrome (CRPS)/Reflex sympathetic dystrophy (RSD); post amputation pain (phantom limb pain); Post herpetic neuralgia; spinal cord injury dysesthesias; pain associated with multiple sclerosis and peripheral vascular disease. In this case, the patient complained of chronic low back pain. Progress reports indicate that the patient had failed all forms of conservative therapy including medications, epidurals and physical therapy. However, they also mention that the patient also medial branch blocks at L3, L4 and L5 bilaterally in November and obtained 75% relief from those injections. To date, there was no recorded subsequent attempt for a second medial branch block. There was also no trial of SNRI or TCAs. These forms of therapy can be done prior to a spinal cord stimulator trial. Therefore, the request for Spinal cord stimulator trial is not medically necessary.

**Ondansetron 8mg #30 no refills:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG (Official Disability Guidelines): Pain Chapter

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

**Decision rationale:** The CA MTUS does not address Ondansetron specifically. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Official Disability Guidelines (Pain, Antiemetics) was used instead. ODG states that Ondansetron is indicated for prevention of nausea and vomiting caused by cancer chemotherapy, radiation therapy and surgery. In this case, the patient was prescribed Ondansetron 8mg prn for vomiting. However, the patient was not on cancer therapy, radiation

therapy or was status-post surgery. Ondansetron is not indicated in this case. Therefore, the request for Ondansetron 8mg #30 no refills is not medically necessary.

**Oxycodone HCL 20mg #180 no refills:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS, ONGOING MANAGEMENT Page(s): 78-81.

**Decision rationale:** As stated on pages 78-80 of CA MTUS Chronic Pain Medical Treatment Guidelines, there are no trials of long-term opioid use in neuropathic pain. Failure to respond to a time-limited course of opioids has led to the suggestion of reassessment and consideration of alternative therapy. Four domains have been proposed as most relevant for ongoing monitoring of CHRONIC pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or nonadherent) drug-related behaviors. The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. In this case, the patient had been taking trazodone for pain since at least October 2013. There is no record to indicate an objective improvement in the patient secondary to this drug in terms of pain reduction and improvement in functionality. Also, there is neither a documentation of a plan to taper the medication nor evidence of a trial to use the lowest possible dose. Side effects were not adequately explored. There is no recent urine drug screen that would provide insight regarding the patient's compliance to the prescribed medication. The medical necessity for continued use is not established because the guideline criteria are not met. Therefore, the request for Oxycodone HCL 20mg #180 no refills is not medically necessary.