

Case Number:	CM14-0169860		
Date Assigned:	10/20/2014	Date of Injury:	08/30/2007
Decision Date:	11/20/2014	UR Denial Date:	09/29/2014
Priority:	Standard	Application Received:	10/14/2014

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 Surgery, has a subspecialty in Spine surgery 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:

According to the records made available for review, this is a 39-year-old male with 8/30/07 date of injury, and status post L5-S1 fusion 6/14/10 and status post re-exploration and mini laminotomy at L5-S1 4/9/12. At the time (9/29/14) of request for authorization for spinal cord stimulator trial, Flexeril 10mg #90, 1 every 8 hours, Ambien 10mg #30, 1 every HS, and Lidoderm 5% #30, there is documentation of subjective (low back pain, lower extremity pain and tingling, mid back pain and spasm, feeling of depression due to disability) and objective (decreased lumbar spine range of motion, positive Minor, Braggards, and Kemp, left L5 and S1 radicular pain) findings, current diagnoses (failed back surgery syndrome, lumbar neuralgia, lumbar facet joint pain, sacroiliac joint pain, opioid dependence, and exogenous depression due to chronic pain), and treatment to date (epidural steroid injection and medications (including gabapentin, Lidoderm patch, Ambien and Flexeril since at least 7/14)). 8/26/14 medical report identifies that the patient has been cleared by Psychology for a spinal cord stimulator trial. Regarding the requested Flexeril 10mg #90, 1 every 8 hours, there is no documentation of an acute exacerbation of chronic low back pain, that Flexeril is being used as a second line option, functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Flexeril use to date, and an intention for short-term (less than two weeks) treatment. Regarding the requested Ambien 10mg #30, 1 every HS, there is no documentation of insomnia and an intention to treat over a short course (less than two to six weeks). Regarding the requested Lidoderm 5% #30, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Lidoderm patch use to date.

IMR ISSUES, DECISIONS AND RATIONALES

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

Spinal cord stimulator trial: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Spinal Cord Stimulators (SCS).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Spinal cord stimulators and CRPS Page(s): 105-107; 38.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of failed back syndrome (persistent pain in patients who have undergone at least one previous back operation), primarily lower extremity pain, less invasive procedures have failed or are contraindicated, and a psychological evaluation prior to a trial, as criteria necessary to support the medical necessity of spinal cord stimulation in the management of failed back syndrome. Within the medical information available for review, there is documentation of diagnoses of failed back surgery syndrome, lumbar neuralgia, lumbar facet joint pain, sacroiliac joint pain, opioid dependence, and exogenous depression due to chronic pain. In addition, there is documentation of failed back syndrome, primarily lower extremity pain, that less invasive procedures have failed, and a psychological evaluation prior to a trial,. Therefore, based on guidelines and a review of the evidence, the request for spinal cord stimulator trial is medically necessary.

Flexeril 10mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63-64. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Muscle relaxants (for pain) Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of acute exacerbation of chronic low back pain and used as a second line option for short-term treatment, as criteria necessary to support the medical necessity of muscle relaxant. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. ODG identifies that muscle relaxants are recommended for short-term (less than two weeks) treatment. Within the medical information available for review, there is documentation of diagnoses of failed back surgery syndrome, lumbar neuralgia, lumbar facet joint pain, sacroiliac joint pain, opioid dependence, and exogenous depression due to chronic pain. However, there is no documentation of an acute exacerbation of chronic low back pain and that Flexeril is being used as a second line option. In addition, given medical records reflecting prescription for Flexeril

since at least 7/14, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Flexeril use to date. In addition, there is no documentation of an intention for short-term (less than two weeks) treatment. Therefore, based on guidelines and a review of the evidence, the request for Flexeril 10mg #90 is not medically necessary.

Ambien 10mg #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Zolpidem (Ambien), Sanofi-Synthelabo, Inc, (March 2004), Ambien (Zolpidem)

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

Decision rationale: MTUS does not address this issue. ODG identifies Ambien (Zolpidem) as a prescription short-acting non-benzodiazepine hypnotic, which is approved for the short-term (usually two to six weeks) treatment of insomnia. Within the medical information available for review, there is documentation of diagnoses of failed back surgery syndrome, lumbar neuralgia, lumbar facet joint pain, sacroiliac joint pain, opioid dependence, and exogenous depression due to chronic pain. However, there is no documentation of insomnia. In addition, given documentation of records reflecting prescriptions for Zolpidem since at least 7/14, there is no documentation of the intention to treat over a short course (less than two to six weeks). Therefore, based on guidelines and a review of the evidence, the request for Ambien 10mg #30 is not medically necessary.

Lidoderm 5% #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 56-57. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of neuropathic pain after there has been evidence that a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica) has failed, as criteria necessary to support the medical necessity of a lidocaine patch. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of failed back surgery syndrome, lumbar neuralgia, lumbar facet joint pain, sacroiliac joint pain, opioid dependence, and exogenous depression due to chronic pain. In addition, there is documentation of neuropathic

pain and trial of first-line therapy (gabapentin). However, given medical records reflecting prescription for Lidoderm patch since at least 7/14, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Lidoderm patch use to date. Therefore, based on guidelines and a review of the evidence, the request for Lidoderm 5% #30 is not medically necessary.