MAXIMUS Federal Services

Case Number:	CM14-0022768		
Date Assigned:	06/11/2014	Date of Injury:	12/15/2004
Decision Date:	07/23/2014	UR Denial Date:	02/18/2014
Priority:	Standard	Application Received:	02/24/2014

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 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 50 year old female who reported an injury on 07/15/2004. The mechanism of injury was not provided for review in the clinical documentation submitted. Per the clinical note dated 01/28/2014, the injured worker complained of increased pain in her neck, right paracervical region, and shoulder. The injured worker was requesting trigger point injections in the right trapezius muscle due to pain and spasm. She also reported significant pain in her right shoulder, which she feels is the result of using a cane in the right hand to compensate for the pain in the right hip and lower extremity. The injured worker reported receiving approximately 40% to 50% benefit from her spinal cord stimulator, with regards to her low back and right lower extremity radicular pain. The current medication regimen prescribed was Oxymorphone, Percocet, Lyrica, and Ambien. Upon physical examination, the provider noted tenderness with spasms in the right paracervical and trapezius muscles. The provider noted the injured worker had pain with range of motion in the right shoulder. There was subacromial tenderness with some restriction in range of motion. The clinical note dated 02/20/2014 the provider indicated the spinal cord stimulator stopped working. The injured worker reported uncontrollable low back and lower extremity pain with medications. The provider noted the injured worker had tenderness with spasms in the right greater than left paralumbar muscles. Range of motion was decreased by pain to 45 degrees in flexion and 5 degrees in extension. The diagnoses included status post permanent implantation of a Medtronic spinal cord stimulator, status post anterior and posterior lumbar fusion, status post multilevel anterior cervical discectomy and fusion, bilateral S1 radicular pain stable with spinal cord stimulator, and opioid dependence. The patient had a spinal cord stimulator implanted, anterior and posterior lumbar fusion, anterior cervical discectomy and fusion. The provider requested oxymorphone for pain relief, Percocet for severe breakthrough pain, Lyrica for radicular pain, Ambien for sleep, a

follow-up with an orthopedic spine surgeon regarding the neck and low back, x-rays of the thoracic spine to check for spinal cord stimulator lead placement, Medtronic re-programming to improve coverage, and trigger point injections to treat pain. The Request for Authorization was provided and dated 02/25/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

90 OXYMORPHONE ER 50 MG BETWEEN 1/30/2014 AND 3/30/2014: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use Page(s): 76-80.

Decision rationale: The MTUS Chronic Pain Guidelines state the ongoing management of opioid use should include ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The MTUS Chronic Pain Guidelines note a pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. The MTUS Chronic Pain Guidelines recommend the use of a urine drug screen or inpatient treatment with issues of abuse, addiction, or poor pain control. The provider did not document an adequate and complete pain assessment within the medical records. There is a lack of documentation indicating the medication had been providing objective functional benefit and improvement. The submitted request failed to provide the frequency of the medication. Additionally, the use of a urine drug screen was not provided in the documentation. The injured worker had been utilizing the medication since at least November 2013. As such, the request is not medically necessary and appropriate.

30 PERCOCET 10/325 BETWEEN 1/30/2014 AND 3/30/2014: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use Page(s): 76-80.

Decision rationale: The MTUS Chronic Pain Guidelines state the ongoing management of opioid use should include ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The MTUS Chronic Pain Guidelines note a pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. The guidelines recommend the use of a urine drug screen or inpatient treatment with issues of abuse, addiction, or poor pain control. The provider did not document an adequate and complete pain assessment within the documentation. There is a lack

of documentation indicating the medication had been providing objective functional benefit and improvement. The submitted request failed to provide the frequency of the medication. Additionally, the use of a urine drug screen was not provided for review in the documentation. The injured worker had been utilizing the medication since at least November of 2013. As such, the request is not medically necessary and appropriate.

120 LYRICA 75 MG BETWEEN 1/28/2014 AND 3/30/2014: 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 Antiepilepsy drugs (AEDs) Page(s): 16-22.

Decision rationale: The MTUS Chronic Pain Guidelines recommend Lyrica for neuropathic pain. The MTUS Guidelines note Lyrica has been documented to be effective in the treatment of diabetic neuropathy and postherpetic neuralgia, has FDA approval for both indications, and is considered a first-line treatment for both. There is lack of objective findings indicating the injured worker has neuropathic pain including sensitivity to light touch. The submitted request failed to provide the frequency of the medication. As such, the request is not medically necessary and appropriate.

15 AMBIEN 10 MG BETWEEN 1/30/2014 AND 3/30/2014: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

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

Decision rationale: The Official Disability Guidelines note Zolpidem is a prescription short-acting non-benzodiazepine hypnotic, which is approved for the short term (usually 2 to 6 weeks) treatment of insomnia. The ODG note proper sleep hygiene is critical to the individual with chronic pain and is often hard to obtain. Various medications may provide short-term benefits. While sleeping pills, so-called minor tranquilizers, and anti-anxiety agents are commonly prescribed in chronic pain, pain specialists rarely, if ever, recommended them for long-term use. The ODG further state, pharmacological agents should only be used after careful evaluation of potential causes of sleep disturbance. The failure of sleep disturbance to resolve in a 7 to 10 day period may indicate a psychiatric and/or medical illness. There is a lack of documentation indicating the injured worker was diagnosed with insomnia. There is a lack of subjective complaints indicating the injured worker has insomnia. The submitted request failed to provide the frequency of the medication. Additionally, the injured worker had been utilizing the medication since at least 08/2013, which exceeds the ODG recommendation of short-term use. As such, the request is not medically necessary and appropriate.

ONE FOLLOW UP WITH ORTHO SPINE SURGEON BETWEEN 1/30/2014 AND 3/30/2014: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Office Visit.

Decision rationale: The MTUS Chronic Pain Guidelines state the ongoing management of opioid use should include ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The MTUS Chronic Pain Guidelines note a pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. The MTUS Chronic Pain Guidelines recommend the use of a urine drug screen or inpatient treatment with issues of abuse, addiction, or poor pain control. The provider did not document an adequate and complete pain assessment within the medical records. There is a lack of documentation indicating the medication had been providing objective functional benefit and improvement. The submitted request failed to provide the frequency of the medication. Additionally, the use of a urine drug screen was not provided in the documentation. The injured worker had been utilizing the medication since at least November 2013. As such, the request is not medically necessary and appropriate.

ONE XRAYS OF THORACIC SPINE TO CHECK SPINAL CORD STIMULATOR LEAD BETWEEN 1/30/2014 AND 3/30/2014: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-182. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 181-183. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Radiography (x-rays).

Decision rationale: Regarding radiography, the ACOEM Guidelines recommend initial studies when red flags for fracture, or neurologic deficit associated with acute trauma, tumor, or infection are present. The Official Disability Guidelines do not recommend routine x-rays in the absence of red flags. The guidelines note the following indications for imaging: severe thoracic spine trauma with pain and no neurological deficit; thoracic spine trauma with neurological deficit; uncomplicated low back pain suspicious of cancer or infection; or post-surgery to evaluate the status of fusion. The clinical documentation submitted does not indicate the injured worker had red flags. The documentation submitted does not indicate the injured worker to have severe trauma or neurological deficits of the spine. There is lack of documentation indicating the stimulator had been checked after placement. As such, the request is not medically necessary and appropriate.

ONE MEET WITH [redacted] REP- REPROGRAMMING BETWEEN 1/30/2014 AND 3/30/2014: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Spinal cord stimulators (SCS) Page(s): 105-107. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Office visits.

Decision rationale: The Official Disability Guidelines state the need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. There is a lack of documentation indicating the need for reprogramming. The provider failed to document a complete and adequate pain assessment. The medical necessity for meeting with reprogramming has not been established. As such, the request is not medically necessary and appropriate.

UNKNOWN TRIGGER POINT INJECTIONS- RIGHT PARACERVICAL AND TRAPEZIUS REGION BETWEEN 1/30/2014 AND 3/30/2014: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Trigger Point Injections Page(s): 122.

Decision rationale: The MTUS Chronic Pain Guidelines recommend trigger point injections for myofascial pain syndrome, with limited lasting value. They are not recommended for radicular pain. Trigger point injections with a local anesthetic may be recommended for treatment of chronic low back or neck pain with myofascial pain syndrome, when all of the following are met: the documentation of circumscribed trigger points with evidence upon palpation of a twitch response, as well as referred pain; symptoms have persisted for more than 3 months; medical management therapy such as ongoing stretching, physical therapy, NSAIDs, and muscle relaxants have failed to control pain; radiculopathy is not present; no more than 3 to 4 injections per session; and no repeat injections unless a greater than 50% pain relief is obtained for 6 weeks after an injection and there is documented evidence of functional improvement. There is a lack of documentation indicating the medication management therapy such as ongoing stretching exercises, physical therapy, NSAIDs, and muscle relaxants have failed to control pain. The submitted request failed to specify the exact location of the trigger point injections. There is lack of significant findings of radiculopathy present. There is lack of documentation indicating the injured worker had trigger points with twitch response. As such, the request is not medically necessary and appropriate.