

Case Number:	CM14-0101705		
Date Assigned:	07/30/2014	Date of Injury:	02/01/1996
Decision Date:	09/22/2015	UR Denial Date:	06/07/2014
Priority:	Standard	Application Received:	07/01/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 (IW) is a 64 year old female who sustained an industrial injury on 02/01/1996. She reported lower back pain. The injured worker is status post laminectomy of L4, L5, and S1 and was diagnosed as having chronic pain post laminectomy. Treatment to date has included medications and implantation of a spinal cord stimulator (02/2003). Currently, the injured worker complains of severe and debilitating pain in the lower back and coccyx with radicular symptoms to both legs. On examination of the cervical spine there is tenderness to palpation along the posterior cervical musculature, there is no bruising or ecchymosis along the cervical, thoracic or lumbar spine, there is tenderness along the lumbar musculature and significant limitation of range of motion in all planes with paraspinal muscle tenderness and spasms noted bilaterally. Straight leg raising is positive bilaterally at about 45 degrees. Examination of the left hip reveals tenderness to palpation along the left greater trochanteric region. There is significantly positive FABERE sign on the left as well as pain with external rotation on the left in comparison to the right. The worker is requiring higher doses of oral analgesic medications and currently is on MS Contin 60 mg three times daily with Norco for breakthrough pain at 6 tablets a day. She has trouble sleeping due to inability to find a comfortable position. She does not leave the house due to pain. She recently fell at home because her "legs gave out". She suffered left rib fracture. Her spinal cord stimulator battery is about 8 years old and the battery may be expiring. She only gets about 30-40% benefit from the spinal cord stimulator now at best. A trial of intrathecal morphine pump is requested along with

the following: Fexmid 7.5mg, #120, Neurontin 600mg, #120, Effexor XR 75mg #30, Restoril 15mg, #60, and 1 Walker (four wheeled with hand brake and seat).

IMR ISSUES, DECISIONS AND RATIONALES

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

1 trial of Intrathecal morphine pump: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Implantable drug-delivery systems (IDDSs) Page(s): 52-54. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Lumbar & Thoracic (Acute & Chronic) Chapter under Implantable drug-delivery systems (IDDSs).

Decision rationale: This patient is status post laminectomy of L4, L5, and S1 and presents with chronic post laminectomy pain. The current request is for 1 trial of Intrathecal morphine pump. The RFA is dated 05/21/14. Treatment to date has included medications, lumbar hardware removal 2004, s/p left sacroiliac joint fusion 2001, physical therapy and implantation of a spinal cord stimulator (02/2003). The patient is not working. MTUS Chronic Pain Medical Treatment Guidelines discusses the use of intrathecal morphine pumps on pages 52-54, under Implantable drug-delivery systems (IDDSs). When used for non-malignant (non-cancerous) pain, MTUS requires that a "Psychological evaluation has been obtained and evaluation states that the pain is not primarily psychological in origin and that benefit would occur with implantation despite any psychiatric co-morbidity." ODG Guidelines, Low Back - Lumbar & Thoracic (Acute & Chronic) Chapter under Implantable drug-delivery systems (IDDSs) states: "Recommended only as an end-stage treatment alternative in selected cases of chronic intractable pain. See the Pain Chapter for Indications for Implantable drug-delivery systems (IDDSs). This treatment should only be used relatively late in the treatment continuum, when there is little hope for effective management of chronic intractable pain from other therapies. For most patients, it should be used as part of a program to facilitate decreased opioid dependence, restoration of function and return to activity, and not just for pain reduction. The specific criteria in these cases include the failure of at least 6 months of other conservative treatment modalities, intractable pain secondary to a disease state with objective documentation of pathology, further surgical intervention is not indicated, psychological evaluation unequivocally states that the pain is not psychological in origin, and a temporary trial has been successful prior to permanent implantation as defined by a 50-70% reduction in pain and medication use." According to progress report 05/21/14, the patient complains of severe and debilitating pain in the lower back and coccyx with radicular symptoms to both legs. There is tenderness along the lumbar musculature and significant limitation of range of motion in all planes with paraspinal muscle tenderness and spasms noted bilaterally. Straight leg raising is positive bilaterally at about 45 degrees. Her spinal cord stimulator battery is about 8 years old and the battery may be expiring. She only gets about 30-40% benefit from the spinal cord stimulator now at best. The treater recommends a trial intrathecal infusion pump before we decide to replace the spinal cores stimulator which is 8 year old. The patient failed back surgery and has a psychological evaluation by [REDACTED] documenting

she is an acceptable candidate for implantable trial. The patient is requiring higher doses of oral analgesic medications due to severe pain and is already currently on MS Contin 60 mg three times daily with Norco for breakthrough pain at 6 tablets a day. She has trouble sleeping due to inability to find a comfortable position and does not leave the house due to pain. A temporary trial of intrathecal (intraspinal) infusion pump is considered medically necessary when all guideline criteria are met. In this case, the patient meets all of the guideline criteria for a spinal pain pump trial. Therefore, the request is medically necessary.

Fexmid 7.5mg, #120: Upheld

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

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

Decision rationale: This patient is status post laminectomy of L4, L5, and S1 and presents with chronic post laminectomy pain. The current request is for Fexmid 7.5mg, #120. The RFA is dated 05/21/14. Treatment to date has included medications, lumbar hardware removal 2004, s/p left sacroiliac joint fusion 2001, physical therapy and implantation of a spinal cord stimulator (02/2003). The patient is not working. MTUS Chronic Pain Guidelines pages 63-66 states: "Muscle relaxants section: Recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbation in patients with chronic LBP. The most commonly prescribed antispasmodic agents are carisoprodol, cyclobenzaprine, metaxalone, and methocarbamol, but despite their popularity, skeletal muscle relaxants should not be the primary drug class of choice for musculoskeletal conditions. Cyclobenzaprine (Flexeril, Amrix, Fexmid, generic available): Recommended for a short course of therapy." According to progress report 05/21/14, the patient complains of severe and debilitating pain in the lower back and coccyx with radicular symptoms to both legs. There is tenderness along the lumbar musculature and significant limitation of range of motion in all planes with paraspinal muscle tenderness and spasms noted bilaterally. Straight leg raising is positive bilaterally at about 45 degrees. The treater requests authorization for a refill of Fexmid. In this case, the patient has been using Fexmid since 01/21/14 and MTUS does not support long-term use of this medication. Most guidelines limited the use to 2 to 3 week period. Hence, the request is not medically necessary.

Neurontin 600mg, #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs (AEDs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin Page(s): 18, 19.

Decision rationale: This patient is status post laminectomy of L4, L5, and S1 and presents with chronic post laminectomy pain. The current request is for Neurontin 600mg, #120. The RFA is dated 05/21/14. Treatment to date has included medications, lumbar hardware removal 2004, s/p left sacroiliac joint fusion 2001, physical therapy and implantation of a spinal cord

stimulator (02/2003). The patient is not working. MTUS has the following regarding Gabapentin on page 18, 19, Anti-epilepsy drugs section: "Gabapentin (Neurontin, Gabarone, generic available) has been shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first-line treatment for neuropathic pain." According to progress report 05/21/14, the patient complains of severe and debilitating pain in the lower back and coccyx with radicular symptoms to both legs. There is tenderness along the lumbar musculature and significant limitation of range of motion in all planes with paraspinal muscle tenderness and spasms noted bilaterally. Straight leg raising is positive bilaterally at about 45 degrees. She has trouble sleeping due to inability to find a comfortable position and does not leave the house due to pain. She only gets about 30-40% benefit from the spinal cord stimulator now at best. This is a request for refill of Neurontin. The patient has been using Neurontin since at least 01/21/14. Progress reports continually document the patient's debilitating pain. The treater states that conservative management therapies have been unsuccessful in reducing pain and is seeking a trial Intrathecal morphine pump. The patient suffers from neuropathic pain for which Neurontin is recommended; however, there is no specific discuss on the efficacy of this medication. The MTUS guidelines page 60 states, "A record of pain and function with the medication should be recorded," when medications are used for chronic pain. Given the lack of discussion regarding medication efficacy, recommendation for further use cannot be made. This request is not medically necessary.

Effexor XR 75mg, #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Effexor (Venlafaxine).

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

Decision rationale: This patient is status post laminectomy of L4, L5, and S1 and presents with chronic post laminectomy pain. The current request is for Effexor XR 75mg, #30. The RFA is dated 05/21/14. Treatment to date has included medications, lumbar hardware removal 2004, s/p left sacroiliac joint fusion 2001, physical therapy and implantation of a spinal cord stimulator (02/2003). The patient is not working. ODG Guidelines under the Pain chapter regarding Effexor states, "Recommended as an option in first-line treatment of neuropathic pain. Venlafaxine - Effexor - is a member of the Selective serotonin and norepinephrine reuptake inhibitors SNRIs-class of antidepressants. It has FDA approval for treatment of depression and anxiety disorders. It is off-label recommended for treatment of neuropathic pain, diabetic neuropathy, fibromyalgia, and headaches." This is a request for refill of Effexor XR. The patient has been using Effexor since at least 01/21/14. Progress reports continually document the patient's debilitating pain. The treater states that conservative management therapies have been unsuccessful in reducing pain and is seeking a trial Intrathecal morphine pump. The patient suffers from chronic neuropathic pain and depression for which Effexor is recommended; however, there is no specific discuss on the efficacy of this medication. The MTUS guidelines page 60 states, "A record of pain and function with the medication should be recorded," when medications are used for

chronic pain. Given the lack of discussion regarding medication efficacy, recommendation for further use cannot be made. This request is not medically necessary.

Restoril 15mg, #60: Upheld

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

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

Decision rationale: This patient is status post laminectomy of L4, L5, and S1 and presents with chronic post laminectomy pain. The current request is for Restoril 15mg, #60. The RFA is dated 05/21/14. Treatment to date has included medications, lumbar hardware removal 2004, s/p left sacroiliac joint fusion 2001, physical therapy and implantation of a spinal cord stimulator (02/2003). The patient is not working. ODG-TWC Guidelines, Pain (Chronic) Chapter, under Insomnia treatment Section states, "FDA-approved benzodiazepines for sleep maintenance insomnia include temazepam (Restoril). These medications are only recommended for short-term use due to risk of tolerance, dependence, and adverse events. Particular concern is noted for patients at risk for abuse or addiction. Benzodiazepines are similar in efficacy to benzodiazepine-receptor agonists; however, the less desirable side-effect profile limits their use as a first-line agent, particularly for long-term use." ODG-TWC Guidelines, Pain (Chronic) Chapter, under Benzodiazepines Section states, "Not recommended for long-term use (longer than two weeks), because long-term efficacy is unproven and there is a risk of psychological and physical dependence or frank addiction. Most guidelines limit use to 4 weeks." This is a request for refill of Restoril. The patient has been using Restoril since at least 01/21/14. Progress reports continually document the patient's debilitating pain. The treater states that conservative management therapies have been unsuccessful in reducing pain and is seeking a trial Intrathecal morphine pump. The patient suffers from chronic sleep issues secondary to pain; however, ODG only recommends benzodiazepines for short-term use, limited to 4 weeks, due to risk of tolerance, dependence, adverse events and side-effect profile. Given this patient has been using this medication chronically, the request is not medically necessary.

1 Walker (four wheeled with hand brake and seat): Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee & Leg (Acute & Chronic) Walking aids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines power mobility devices Page(s): 99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee Chapter under Walking Aids.

Decision rationale: This patient is status post laminectomy of L4, L5, and S1 and presents with chronic post laminectomy pain. The current request is for 1 Walker (four wheeled with hand brake and seat). The RFA is dated 05/21/14. Treatment to date has included medications, lumbar hardware removal 2004, s/p left sacroiliac joint fusion 2001, physical therapy and implantation of a spinal cord stimulator (02/2003). The patient is not working. MTUS Chronic Pain Guidelines page 99, discusses walkers in the context of power mobility devices, stating "if the functional mobility deficit can be sufficiently resolved by the prescription of a cane or walker, or the patient has sufficient upper extremity function to propel a manual wheelchair, or there is a caregiver who is available, willing, and able to provide assistance with a manual wheelchair. Early exercise, mobilization and independence should be encouraged at all steps of the injury recovery process, and if there is any mobility with canes or other assistive devices, a motorized scooter is not essential to care." ODG Guidelines, Knee Chapter under Walking Aids states: "Recommended for patients with conditions causing impaired ambulation when there is a potential for ambulation with these devices." According to progress report 05/21/14, the patient complains of severe and debilitating pain in the lower back and coccyx with radicular symptoms to both legs. There is tenderness along the lumbar musculature and significant limitation of range of motion in all planes with paraspinal muscle tenderness and spasms noted bilaterally. Straight leg raising is positive bilaterally at about 45 degrees. Due to instability, the patient had a recent fall at home and suffered left rib fracture. It was noted that the patient requires a four-wheel walker with brake and seat as she is severely deconditioned and remains a high fall risk. The patient clearly has issues with ambulation and stability and the treater's request for a walker appears reasonable and consistent with ODG Guidelines. The four wheeled walker would be safer, prevent deterioration secondary to non-use, and hopefully improve this patient's functional status and overall outcome. Therefore, the request is medically necessary.