

<b>Case Number:</b>	CM14-0188276		
<b>Date Assigned:</b>	11/18/2014	<b>Date of Injury:</b>	05/27/1997
<b>Decision Date:</b>	02/10/2015	<b>UR Denial Date:</b>	11/03/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/12/2014

### 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 Occupational Medicine and is licensed to practice in Massachusetts. 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 47-year-old female who reported an injury on 05/27/1997. The mechanism of injury was lifting. Her diagnoses included thoracic/lumbosacral neuritis/radiculitis unspecified, lumbago, postlaminectomy syndrome lumbar region, intervertebral lumbar disc disorder with myopathy and degenerative lumbosacral intervertebral disc. Her past treatments included surgery, medications, steroid injections, physical therapy, chiropractic sessions, and spinal cord stimulator placement. Her diagnostic studies included a CT scan of the lumbar spine performed on 04/22/2009, which revealed a 4 mm disc protrusion at the L3-4, L4-5, and L5-S1. Her surgical history included lumbar laminectomy, gastric bypass, left elbow surgery, surgical ligation, hysterectomy, and a spinal cord stimulator implant. The progress note dated 10/24/2014 indicated the injured worker complained of chronic severe low back pain that radiated to her bilateral legs and feet. Physical examination of the lumbar and sacral spine indicated abnormal palpation and tenderness to the L4-5 and decreased sensation to the left L4, L5, and S1, and the right L5 and S1. It was also indicated that deep tendon reflexes in the lower extremities were equal but decreased. There was also decreased strength in bilateral lower extremities. Her medications included morphine sulfate 30 mg, Norco 10/325 mg, Xanax 0.5 mg, tizanidine hcl 2 mg, Ambien 5 mg, diclofenac 150 mg, Medrol 4 mg, Valium 10 mg, and Soma 350 mg. The injured worker rated her pain without medication at 9/10 and with medication 2/10. It was indicated that the injured worker received relief from the spinal cord stimulator when functional and that she relied heavily on it for pain relief. However, the device could not be read at the clinical visit due to the battery being discharged. Her treatment plan included medication renewal and continued home exercise program. The request was for spinal cord stimulator revision/replacement, preoperative testing, a urine drug screen, an electrocardiogram, a chest x-ray, a medical clearance evaluation with an anesthesiologist/internal

medicine specialist, repeat caudal epidural steroid injection, a trial of Nucynta ER 50 mg, tizanidine hydrochloride 2 mg, and Ambien 5 mg. The Request for Authorization form dated 10/24/2014 was submitted for review, however, the rationale for the request was not included.

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

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

#### **Spinal Cord Stimulator Revision/Replacement to MRI Compatible Device, Battery and Leads: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 107. Decision based on Non-MTUS Citation Official Disability Guidelines- pain chapter, spinal cord stimulators (SCS)

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

**Decision rationale:** The Official Disability Guidelines indicate as batteries for both rechargeable and non-rechargeable systems are nearing end of life, there are both early replacement indicators and end of service notifications. For spinal cord stimulators, typical life may be 8 to 9 years for rechargeable batteries, but this depends on the unit. In addition, the physician programmer can be used to integrate the implanted device and determine the estimated remaining battery life. While clinical documentation submitted indicated that the spinal cord stimulator battery for the injured worker was about to fail, the programming session was not submitted for review. There was a lack of documentation to show evidence that the battery was failing. Additionally, there was also a lack of documentation to demonstrate medical necessity for an MRI compatible device. Due to this lack of clinical evidence provided and using the evidence based, peer reviewed guidelines referenced, the request for a spinal cord stimulator revision/replacement to MRI compatible device, battery and leads is not medically necessary.

#### **Complete Blood Count: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines- low back chapter, preoperative testing

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

#### **Comprehensive metabolic panel: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines- low back chapter, preoperative testing

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Prothrombin time/Partial thromboplastin time:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines- low back chapter, preoperative testing

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**International normalized ration (INR):** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines- low back chapter, preoperative testing

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Urine drug screen:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 43.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Electrocardiogram:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines- low back chapter, preoperative testing

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Chest X-ray:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines- low back chapter, preoperative testing

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Medical Clearance evaluation with anesthesiologist /internal medicine specialist:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines- back chapter, office visits American college of occupational and environmental medicine (ACOEM), occupational medical practice guidelines, chapter 7, page 127

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Repeat Caudal Epidural Steroid Injection Performed under Fluoroscopic Guidance and Monitored Anesthesia:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 46.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections Page(s): 46.

**Decision rationale:** The request for repeat caudal epidural steroid injection performed under fluoroscopic guidance and monitored anesthesia is not medically necessary. The California MTUS Guidelines recommend epidural steroid injections as an option for treatment of radicular pain when radiculopathy is documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. Repeat injections should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for 6 to 8 weeks. The progress note dated 10/22/2014 indicated the injured worker received more than 70% relief from the previous epidural steroid

injection, however, the injured worker continued to report no change in her low back pain intensity or distribution. While physical examination revealed decreased strength and decreased deep tendon reflexes in the bilateral lower extremities, there was a lack of documentation to evidence a significant neurological deficit in the injured worker. Also, there was a lack of imaging studies and/or electrodiagnostic testing to corroborate significant pathology or radiculopathy. There was also a lack of documentation demonstrating decreased medication usage and significant objective functional improvement following the previous injection. Based on the clinical information submitted for this review and using evidence based peer reviewed guidelines, the request for a repeat caudal epidural steroid injection performed under fluoroscopic guidance and monitored anesthesia is not medically necessary.

**Trial of Nucynta Extended release 50mg: Upheld**

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

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

**Decision rationale:** The request for trial of Nucynta extended release 50mg is not medically necessary. The Official Disability Guidelines recommend Nucynta only as a second line therapy for patients who develop intolerable adverse effects with first line opioids. It was indicated that the injured worker was prescribed morphine sulfate 30 mg and Norco 10/325 mg. However, there was a lack of documentation indicating the injured worker had any adverse effects from the medications prescribed. Additionally, the request as submitted does not indicate the frequency of use of the medication in order to determine medical necessity. Due to the lack of documentation indicating the injured worker developed an intolerable adverse effect from the medications prescribed, and using the evidence based, peer reviewed guidelines, the request for a trial of Nucynta extended release 50mg is not medically necessary.

**Tizanidine HCL 2mg #270 with 3 refills: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 66.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63.

**Decision rationale:** The request for Tizanidine HCL 2mg #270 with 3 refills is not medically necessary. The California MTUS Guidelines recommend non-sedating muscle relaxants with caution as a second line option for short term treatment of acute exacerbations in patients with chronic low back pain. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. The clinical documentation indicated that the injured worker had been prescribed Tizanidine, however, the actual start date and duration of use

for the medication was not provided. Additionally, the request as submitted failed to indicate a frequency of use for the medication to determine medical necessity. As such, the request for Tizanidine HCL 2mg #270 with 3 refills is not medically necessary.

**Ambien 5mg #60 with 3 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 66.

**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 (Ambien®)

**Decision rationale:** The request for Ambien 5mg #60 with 3 refills is not medically necessary. The Official Disability Guidelines recommend Ambien for short term (7 to 10 days) treatment of insomnia. The Official Disability Guidelines indicate proper sleep hygiene is critical to the individual with chronic pain and often is hard to obtain. The guidelines also indicate while sleeping pills, so called minor tranquilizers and antianxiety agents are commonly prescribed in chronic pain, pain specialists rarely, if ever recommend them for long term use. They can be habit forming, and they may impair function and memory more than opioid pain relievers. While clinical documentation indicated the injured worker had been prescribed Ambien, there was a lack of documentation to indicate the start date of the medication or the duration of use. Additionally, the request as submitted failed to indicate a frequency of use for the medication in order to determine medical necessity. As such, the request for Ambien 5mg #60 with 3 refills is not medically necessary.

**Morphine Sulfate 30mg #240:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 80-95.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 78.

**Decision rationale:** The request for Morphine Sulfate 30mg #240 is not medically necessary. The California MTUS Guidelines recommend ongoing review of opioid use, including documentation of pain relief, functional status, appropriate medication use, and side effects. It should include current pain, intensity of pain before and after taking the opioid, how long it takes for pain relief, and how long the pain relief lasts. A satisfactory response to treatment may be indicated by decreased pain, increased level of function, or improved quality of life. Clinical documentation indicated the patient reported pain average of 9/10 without medication and 2/10 with medication; however documentation failed to provide evidence of objective functional improvement, indication of side effects, or evidence of appropriate medication use, such as a recent urine drug screening. Additionally, the request as submitted failed to indicate a frequency of use to establish medical necessity for the request. As such, the request for Morphine Sulfate 30mg #240 is not medically necessary.

**Xanax 0.5mg #60 with 1 refill:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 24.

**Decision rationale:** The request for Xanax 0.5mg #60 with 1 refill is not medically necessary. The California MTUS Guidelines do not recommend benzodiazepines for long term use because long term efficacy is unproven, and there is a risk of dependence. Most guidelines limit use to 4 weeks, and guidelines indicate chronic benzodiazepines are the treatment of choice in very few conditions. It was indicated that the injured worker had been prescribed Xanax; however, the documentation provided failed to indicate a start date or duration of use for the medication. As guidelines do not recommend long term use of benzodiazepines, the continuation of Xanax is not supported. Additionally, the request as submitted failed to indicate a frequency of use to establish medical necessary for the request. As such, the request for Xanax 0.5mg #60 with 1 refill is not medically necessary.