

Case Number:	CM14-0218946		
Date Assigned:	02/11/2015	Date of Injury:	05/22/1997
Decision Date:	04/08/2015	UR Denial Date:	12/12/2014
Priority:	Standard	Application Received:	12/30/2014

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: New York
 Certification(s)/Specialty: Anesthesiology

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 51 year old male who sustained an industrial related injury on 5/22/97. The injured worker had complaints of back pain that radiated to the right leg. Diagnoses included post cervical laminectomy syndrome, post lumbar laminectomy syndrome, and cervical radiculopathy. Treatment included placement of a pain pump. Medications included Seroquel, Fentanyl/Bupivacaine, Dilaudid, and Diazepam. The treating physician requested authorization for Seroquel 400mg #34, Diazepam 10mg #2, Fentanyl 10mg/ml and Bupivacaine 150mcg/ml #40ml, Dilaudid 8mg #90, closed MRI of the thoracic spine, closed MRI of the lumbar spine, genetic testing for resistance to opioids, and referral for consideration of IT pump increase. On 12/12/14 the requests were modified or non-certified. Regarding Seroquel, the utilization review (UR) physician cited the Official Disability Guidelines (ODG) and noted this medication is non-certified due to lack of support as a first-line treatment option. Regarding Diazepam, the UR physician cited the Medical Treatment Utilization Schedule (MTUS) guidelines and noted the injured worker had been using this medication since June 2014, which exceeds guideline recommendations for short term use. Therefore, the request was non-certified. Regarding Fentanyl and Bupivacaine, the UR physician cited the MTUS guidelines and noted the request was modified for weaning as the medical records did not provide evidence of functional improvement with intrathecal opiates. Regarding Dilaudid, the UR physician cited the MTUS guidelines and noted the request was non-certified due to no recent progress reports containing documentation of improved function or potential for returning to work. Regarding the MRIs, the UR physician cited the MTUS guidelines and note the medical records did not document

neurological deficits related to the thoracic or lumbar spine to necessitate an MRI. Regarding genetic testing, the UR physician cited ODG and noted the request was non-certified as there is no guideline support due to lack of evidence and efficacy. Regarding the referral for IT pump increase, the UR physician cited ODG and noted the request was non-certified due to the absence of clinical evidence of meaningful treatment efficacy.

IMR ISSUES, DECISIONS AND RATIONALES

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

One prescription of Seroquel 400mg #34: 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).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Seroquel (Quetiapine), Atypical Anti-psychotics.

Decision rationale: According to ODG, Seroquel (Quetiapine) is an atypical anti-psychotic medication. Anti-psychotic drugs are not recommended as first-line treatment to treat behavioral problems. There is insufficient evidence to recommend atypical anti-psychotics, such as, Seroquel, for conditions covered in ODG. There is insufficient evidence to recommend atypical anti-psychotics for the treatment of PTSD. There is no specific documentation indicating that this medication is indicated for the treatment of a chronic pain condition. Antipsychotic drugs are commonly prescribed off-label for a number of disorders outside of their FDA-approved indications, schizophrenia and bipolar disorder. Medical necessity for the requested medication is not established. The requested medication is not medically necessary.

One prescription of Diazepam 10mg #2: Upheld

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

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

Decision rationale: According to CA MTUS Guidelines, benzodiazepines are prescribed for anxiety. They are not recommended for long-term use for the treatment of chronic pain because long-term efficacy is unproven and there is a risk of dependency. Valium (Diazepam) is a long-acting benzodiazepine, having anxiolytic, sedative, and hypnotic properties. Most guidelines recommend the use of Valium for the treatment of anxiety disorders, and as an adjunct treatment for anxiety associated with major depression. Use of this medication is limited to four weeks. The documentation indicates the patient had been taking Valium since 6/2014, which exceeded the guideline recommendations. In addition, there is documentation indicating that the patient had been weaned off Valium therapy. There is no indication for the requested Valium. Medical

necessity for the requested medication has not been established. The requested medication is not medically necessary.

One prescription of Fentanyl 10mg/ml and Bupivacaine 150mcg/ml #40ml: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Implantable Drug-Delivery Systems Page(s): 53.

Decision rationale: Permanently implanted intrathecal infusion pumps are used for the administration of opiates or non-opiate analgesics in the treatment of chronic intractable pain. Implantable drug delivery systems (IDDSs) are recommended only as an end-stage treatment alternative for selected patients for specific conditions, per CA MTUS (2009) criteria (pp. 53-54), after failure of at least 6 months of less invasive methods, and following a successful temporary trial. MTUS guidelines recommend the continued use of an intrathecal IDDS if there is documentation of pain relief and functional improvement. A satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, return to work, or improved quality of life. The guidelines state that the pump may need to be refilled at regular intervals, with time between intervals based on the reservoir size, drug concentration, dose, and flow rate. A programming session, which may occur along with or independent of a refill session, allows the clinician to adjust the patient's prescription as well as record or recall important information about the prescription. Morphine is generally the initial intrathecal DDS medication. Dilaudid is an alternative IDDS, however, non-FDA approved. Fentanyl has been used for intrathecal chronic non-malignant pain, but is non-FDA approved and there is little research associated with its use. It is apparent that even intrathecal opiates, when administered in the long term, can be associated with problems, such as tolerance and hyperalgesia. Consequently, long-term efficacy has not been proven. In this case, the documentation indicates that since the implantation of the pump in April, 2013, there have been two pump increases with the most recent performed in May, 2014. Following both increases there have been no reported improvements in the patient's symptoms. The patient continues with an 8-9/10 pain level with decreased activity level and no improvement in sleep quality. There is no indication for continuation of intrathecal Fentanyl and Bupivacaine therapy at the present dosage. Opiates should not be abruptly discontinued, but a pump refill of tapered intrathecal narcotic (Fentanyl) would prevent withdrawal effects. Medical necessity for the requested IDDS medications is not established. The requested intrathecal Fentanyl and Bupivacaine is not medically necessary.

One prescription of Dilaudid 8mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for the treatment of Chronic Pain.

Decision rationale: According to ODG, chronic pain can have a mixed physiologic etiology of both neuropathic and nociceptive components. In most cases, analgesic treatment should begin with acetaminophen, aspirin, and NSAIDs. When these drugs do not satisfactorily reduce pain, opioid analgesics for moderate to severe pain, such as Dilaudid, may be added. These medications are generally classified according to potency and duration of dosage duration. The treatment of chronic pain with any opioid analgesic requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. A pain assessment should include current pain, intensity of pain after taking the opiate, and the duration of pain relief. In this case, there is no documentation of the medication's pain relief effectiveness or response to ongoing narcotic analgesic therapy. There is no documentation of objective functional improvement as a result of this medication, such as range of motion or strength testing. Medical necessity of the requested narcotic analgesic, Dilaudid, has not been established. Of note, discontinuation of an opiate/narcotic analgesic should include a taper to avoid withdrawal symptoms. The certification of the requested medication is not medically necessary.

One closed MRI of thoracic spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

Decision rationale: AECOM Guidelines state that for most true neck and upper back problems, special studies, such as an MRI (magnetic resonance imaging), are not indicated unless a neurologic deficit is documented on physical exam, failure to progress in a strengthening program, or for clarification of the anatomy prior to an invasive procedure. There is no documentation of any neurological deficit(s) related to the thoracic spine to necessitate an MRI of the thoracic spine. Medical necessity for the requested service is not established. The requested closed MRI of the thoracic spine is not medically necessary.

One closed MRI of lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 53.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MRI of the LS spine Page(s): 304.

Decision rationale: According to California MTUS Guidelines, MRI of the lumbar spine is recommended to evaluate for evidence of cauda equina, tumor, infection, or fracture when plain films are negative and neurologic abnormalities are present on physical exam. In this case, there is no indication for an MRI of the lumbar spine. There are no subjective complaints of increased back pain, radiculopathy, bowel or bladder incontinence, and there are no new neurologic findings on physical exam. Therefore, there is no specific indication for an MRI of the lumbar

spine. Medical necessity for the requested MRI has not been established. The requested imaging is not medically necessary.

One genetic testing for resistance to opioids [pharmacogenetic testing]: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM, Chronic Pain Treatment 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 Chapter.

Decision rationale: ODG states that genetic (cytokine DNA) testing for resistance to opioids is not a standard practice in pain management. There is no support for this laboratory study in ODG. There is no current evidence to support the use of cytokine DNA testing for the diagnosis of pain, including chronic pain. The documentation indicates that this patient is maintained on an intrathecal pain pump. Medical necessity for the requested laboratory study is not established. The requested laboratory study is not medically necessary.

One referral for consideration of IT pump purchase: 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).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Implantable Drug-Delivery Systems (IDDS) Page(s): 52-54. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Implantable Drug-Delivery Systems (IDDS).

Decision rationale: Permanently implanted intrathecal infusion pumps are used for the administration of opiates or non-opiate analgesics in the treatment of chronic intractable pain. Implantable drug delivery systems (IDDSs) are recommended only as an end-stage treatment alternative for selected patients for specific conditions, per CA MTUS (2009) criteria (pp. 53-54), after failure of at least 6 months of less invasive methods, and following a successful temporary trial. MTUS guidelines recommend the continued use of an intrathecal IDDS if there is documentation of pain relief and functional improvement. A satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, return to work, or improved quality of life. The guidelines state that the pump may need to be refilled at regular intervals, with time between intervals based on the reservoir size, drug concentration, dose, and flow rate. A programming session, which may occur along with or independent of a refill session, allows the clinician to adjust the patient's prescription as well as record or recall important information about the prescription. In this case, a pump refill was determined to not be medically necessary based on the treatment efficacy. Considering the lack of substantial improvement with a high intrathecal pump dosage, an additional increase in dosage is not indicated according to the guidelines. Medical necessity for the requested referral for consideration of the IT pump increase has not been established. The request for this referral is not medically necessary.