

Case Number:	CM14-0073217		
Date Assigned:	07/16/2014	Date of Injury:	01/25/2012
Decision Date:	01/27/2015	UR Denial Date:	04/18/2014
Priority:	Standard	Application Received:	05/20/2014

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 Family Practice and is licensed to practice in Ohio. 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 38-year-old female who had a slip and fall injury January 25, 2012 whereby she injured her lower back. She a subsequent slip and fall injury November 8, 2012 whereby she injured the right elbow, shoulder, and knee, and reaggravated her back injury. She complains primarily of low back pain radiating to the right lower extremity. An MRI scan of the lumbar spine from 2013 revealed a 2 mm disc bulge at L4-L5 resulting in moderate bilateral neuroforaminal stenosis and facet joint hypertrophy. Electrodiagnostic testing of the lower extremities from July 11, 2012 revealed severe right-sided L5 neuropathy, marked left L5 neuropathy, and mild L1 pathology. She has received lumbar facet injections to L3-L4 and L4-L5 bilaterally without much success. She's received 2 rounds of bilateral sacroiliac joint blocks achieving pain relief for 2 hours only. She was prescribed Lyrica 50 mg at bedtime and noted near complete relief after couple of days with resumption of pain when she ran out of the samples. She's been on a variety of opiates. On April 9, 2014, while on oxycontin 30 mg three times a day, it was noted that her pain levels dramatically improved from a 6/10 to a 2/10 which allowed her to maintain her work and home duties. The physical exam at that time revealed diminish lumbar range of motion with tenderness to palpation of the sacroiliac joints and the lumbar paraspinal muscles. Previous physical exams had noted diminished sensation on the right side in the regions of L4, L5, and S1 dermatome regions. At issue is a request for sacroiliac joint radiofrequency ablation, lidocaine patches #30, OxyContin 30 mg #30, Lyrica 50 mg #30 with 3 refills, and Robaxin 500 mg #90 with 3 refills. These requests were previously not certified citing CA MTUS and ODG guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Oxycontin 30mg, #90: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96.

Decision rationale: Those patients prescribed opiates chronically should have ongoing assessment for pain relief, functionality, medication side effects, and aberrant drug taking behavior. Generally, opiates may be continued if there are improvements in pain and functionality and/or the patient has returned to work. In this instance, it is documented that the injured worker has returned to her employment and that she had improvements in pain levels and functionality as a consequence of the medication. The previous reviewer noted a urine drug screen which was inconsistent in that it showed evidence of benzodiazepines. This reviewer found one urine drug screen dated March 27, 2014. That urine drug screen did not reveal the presence of non-prescribed substances like benzodiazepines. Therefore, Oxycontin 30mg, #90 was medically necessary.

Lyrica 50mg, #30 with 3 refills: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epileptic drugs Page(s): 16-17.

Decision rationale: Anti-epileptic drugs (AEDs) are recommended for neuropathic pain (pain due to nerve damage). Most randomized controlled trials (RCTs) for the use of this class of medication for neuropathic pain have been directed at postherpetic neuralgia and painful polyneuropathy (with diabetic polyneuropathy being the most common example). There are few RCTs directed at central pain and none for painful radiculopathy. The choice of specific agents reviewed below will depend on the balance between effectiveness and adverse reactions. A "good" response to the use of AEDs has been defined as a 50% reduction in pain and a "moderate" response as a 30% reduction. It has been reported that a 30% reduction in pain is clinically important to patients and a lack of response of this magnitude may be the "trigger" for the following: (1) a switch to a different first-line agent (TCA (tricyclic antidepressants), SNRI (serotonin-norepinephrine reuptake inhibitors) or AED are considered first-line treatment); or (2) combination therapy if treatment with a single drug agent fails. In this instance, the injured worker reported a dramatic pain reduction with the use of Lyrica. She has clear evidence of neuropathic pain as evidenced by results of electrodiagnostic testing done 7-11-2012. Therefore Lyrica 50mg, #30 with 3 refills was medically necessary.

Robaxin 500mg, #90 with 3 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 63 and 65.

Decision rationale: The referenced guidelines recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP. Muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in most LBP (low back pain) cases, they show no benefit beyond NSAIDs in pain and overall improvement. Also there is no additional benefit shown in combination with NSAIDs. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. Sedation is the most commonly reported adverse effect of muscle relaxant medications. The mechanism of action of the muscle relaxant Robaxin is unknown, but appears to be related to central nervous system depressant effects with related sedative properties. In this instance, Robaxin appears to have been in continuous use October 2013. This time frame places the use of this sedating muscle relaxant well past that recommended by the referenced guidelines. Therefore Robaxin 500mg, #90 with 3 refills was not medically necessary.

Lidocaine patches topical, #30: Upheld

Claims Administrator guideline: Decision based on MTUS 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 (Chronic), Lidoderm® (lidocaine patch)

Decision rationale: Per the Official Disability Guidelines, the criteria for use of Lidoderm patches are: (a) Recommended for a trial if there is evidence of localized pain that is consistent with a neuropathic etiology. (b) There should be evidence of a trial of first-line neuropathy medications (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). (c) This medication is not generally recommended for treatment of osteoarthritis or treatment of myofascial pain/trigger points. (d) An attempt to determine a neuropathic component of pain should be made if the plan is to apply this medication to areas of pain that are generally secondary to non-neuropathic mechanisms (such as the knee or isolated axial low back pain). One recognized method of testing is the use of the Neuropathic Pain Scale. (e) The area for treatment should be designated as well as number of planned patches and duration for use (number of hours per day). (f) A Trial of patch treatment is recommended for a short-term period (no more than four weeks). (g) It is generally recommended that no other medication changes be made during the trial period. (h) Outcomes should be reported at the end of the trial including improvements in pain and function, and decrease in the use of other medications. If improvements cannot be determined, the medication should be discontinued. (i) Continued outcomes should be intermittently measured and if improvement does not continue, lidocaine

patches should be discontinued. In this instance, the intended area of application for the lidocaine patches is not specified within the notes provided. It is unclear if this request represents a new prescription or a continuation of a previous prescription which would necessitate documentation of a previous trial. The reviewed record does not contain evidence of a previous trial. The necessity for the addition of a lidocaine patch to the medication regimen which already includes Lyrica is not established. The reasons for adding a lidocaine patch to a regimen containing low dose Lyrica are not provided. Consequently, Lidocaine patches topical, #30 were not medically necessary.

SI joint radiofrequency ablation: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Hip and Pelvis, Sacroiliac joint radiofrequency neurotomy

Decision rationale: Sacroiliac joint radiofrequency neurotomy is not recommended by the Official Disability Guidelines. Multiple techniques are currently described: (1) a bipolar system using radiofrequency probes; (2) sensory stimulation-guided sacral lateral branch radiofrequency neurotomy (Yin, W 2003); (3) lateral branch blocks (nerve blocks of the L4-5 primary dorsal rami and S1-S3 lateral branches); & (4) pulsed radiofrequency denervation (PRFD) of the medial branch of L4, the posterior rami of L5 and lateral branches of S1 and S2. This latter study applied the technique to patients with confirmatory block diagnosis of SI joint pain that did not have long-term relief from these diagnostic injections (22 patients). There was no explanation of why pulsed radiofrequency denervation was successful when other conservative treatment was not. A > 50% reduction in VAS (visual analog scale) score was found for 16 of these patients with a mean duration of relief of 20 5.7 weeks. The use of all of these techniques has been questioned, in part, due to the fact that the innervation of the SI joint remains unclear. There is also controversy over the correct technique for radiofrequency denervation. A recent review of this intervention in a journal sponsored by the American Society of Interventional Pain Physicians found that the evidence was limited for this procedure. Therefore, sacroiliac joint radiofrequency neurotomy was not medically necessary.