MAXIMUS Federal Services

Case Number:	CM15-0001321		
Date Assigned:	01/12/2015	Date of Injury:	07/21/2009
Decision Date:	03/09/2015	UR Denial Date:	12/17/2014
Priority:	Standard	Application Received:	01/05/2015

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: Indiana
Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This employee is a 56 year old female with date of injury of 7/21/2009. A review of the medical records indicate that the patient is undergoing treatment for lumbar degenerative disc disease. Subjective complaints include continued pain in the lower back with radiation to low extremity. Objective findings include limited range of motion of the lumbar spine with tenderness to palpation of the paravertebrals; positive straight leg raise; MRI showing disc bulges at L3-L4 and L4-L5. Treatment has included physical therapy, TENS unit, home exercises, Vimovo, Lidoderm patch, Vicodin ,and Voltaren gel. The utilization review dated 12/17/2014 non-certified a lumbar right TFE at L3-4, Dilaudid 2mg, Ambien 5mg #15, and Lidocaine 5% #60.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar right TFE at L3-4: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 46-49.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287-315,Chronic Pain Treatment Guidelines ESI Page(s): 46. Decision based on Non-MTUS Citation Low Back, ESI

Decision rationale: MTUS Chronic pain medical treatment guidelines state that epidural steroid injections are "Recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy)… Epidural steroid injection can offer short term pain relief and use should be in conjunction with other rehab efforts, including continuing a home exercise program. There are no objective findings were documented to specify the dermatomal distribution of pain. MTUS further defines the criteria for epidural steroid injections to include: 1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). 3) Injections should be performed using fluoroscopy (live x-ray) for guidance. 4) If used for diagnostic purposes, a maximum of two injections should be performed. A second block is not recommended if there is inadequate response to the first block. Diagnostic blocks should be at an interval of at least one to two weeks between injections. 5) No more than two nerve root levels should be injected using transforaminal blocks. 6) No more than one interlaminar level should be injected at one session. 7) In the therapeutic phase, repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year. (Manchikanti, 2003) (CMS, 2004) (Boswell, 2007) 8) Current research does not support a series-of-three injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections." Radiculopathy does not appear to be documented with both physical exam and imaging studies. The patient is taking multiple medications, but the progress reports do not document how long the patient has been on these medications and the unresponsiveness to the medications. Additionally, treatment notes do not indicate if other conservative treatments were tried and failed (exercises, physical therapy, etc). As such, the request for Lumbar right TFE at L3-4 is not medically necessary.

Dilaudid 2mg 1 qhs: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 79-81.

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

Decision rationale: Per MTUS, Dilaudid is the brand name version of Hydromorphone, which is a pure agonist/short acting opioid and they are often used for intermittent or breakthrough pain. ODG does not recommend the use of opioids for low back pain except for short use for severe cases, not to exceed 2 weeks. The patient has exceeded the 2 week recommended treatment length for opioid usage. MTUS does not discourage use of opioids past 2 weeks, but does state that ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. 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. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. The treating physician does not document any of the following: the least reported pain over the period since last assessment, intensity of pain after taking opioid, pain relief. As such, the question for Dilaudid 2mg, is not medically necessary.

Ambien 5mg 1/2 qhs #15: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Formulary

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Pain; Insomnia; Zolpidem

Decision rationale: The CA MTUS silent regarding this topic. ODG states that zolpidem is a prescription short acting non-benzodiazepine hypnotic, which is approved for short-term treatment of insomnia. In this case, the patient has been taking this medication as early as July 2013. There has been no discussion of the patient's sleep hygiene or the need for variance from the guidelines, such as: a) Wake at the same time everyday; (b) Maintain a consistent bedtime; (c) Exercise regularly (not within 2 to 4 hours of bedtime); (d) Perform relaxing activities before bedtime; (e) Keep your bedroom quiet and cool; (f) Do not watch the clock; (g) Avoid caffeine and nicotine for at least six hours before bed; (h) Only drink in moderation; & (i) Avoid napping. Medical documents also do not include results of these first line treatments, if they were used in treatment of the patient's insomnia. ODG additionally states: The specific component of insomnia should be addressed: (a) Sleep onset; (b) Sleep maintenance; (c) Sleep quality; & (d) Next-day functioning. Medical documents provided do not detail these components. As such, the request for Ambien is not medically necessary at this time.

Lidocaine 5% 1-2 patches #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidocaine patches Page(s): 56-57. Decision based on Non-MTUS Citation Pain, Topical Analgesics

Decision rationale: Chronic Pain Medical Treatment Guidelines state: Lidoderm is the brand name for a lidocaine patch produced by Endo Pharmaceuticals. Topical lidocaine may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). This is not a first-line treatment and is only FDA approved for post-herpetic neuralgia. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than post-herpetic neuralgia. Formulations that do not involve a dermal-patch system are generally indicated as local anesthetics and anti-pruritics. For more information and references, see Topical analgesics. ODG further details: Criteria for use of Lidoderm patches: (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. Medical documents provided do not indicate that the use would be for post-herpetic neuralgia. Additionally, treatment notes did not detail other first-line therapy used and what the clinical outcomes resulted. As such, the request for Lidoderm 5% patches is not medically necessary.