

Case Number:	CM15-0100090		
Date Assigned:	06/02/2015	Date of Injury:	02/04/1998
Decision Date:	07/09/2015	UR Denial Date:	04/21/2015
Priority:	Standard	Application Received:	05/26/2015

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: 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:

This 44 year old female sustained an industrial injury to the right wrist and back on 2/4/98. Recent treatment included spinal cord stimulator, psychological care and medications. In a progress note dated 3/11/15, the injured worker reported having difficulty tolerating a medication wean. The injured worker had attempted to lower medications many times with significant increase in pain and difficulty functioning. The injured worker was using her spinal cord stimulator 24 hours per day. The physician noted that he felt the injured worker was currently at her lowest level and ability to wean on an outpatient basis. Current diagnoses included complex regional pain syndrome, neuropathic pain to bilateral upper and lower extremities, insomnia, situational depression, opioid dependency and lumbar spine radiculopathy. The physician recommended holding the weaning schedule, continuing current medications (Fentanyl, Actiq, Lyrica, Remeron and Tizanidine), lumbar epidural steroid injections, continuing spinal cord stimulator use and a 10-day inpatient detoxification program.

IMR ISSUES, DECISIONS AND RATIONALES

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

Actiq 0.5mg #180: 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), Pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Actiq/fentanyl lollipop Page(s): 12.

Decision rationale: This patient presents with chronic back and right wrist pain. The current request is for Actiq 0.5mg #180. The Request for Authorization is not provided in the medical file. Previous treatments included physical therapy, spinal cord stimulator, psychological care and medications. The patient is not working. MTUS Chronic Pain Medical Treatment Guidelines, page 12 for Actiq/fentanyl lollipop states "Not recommended for musculoskeletal pain." This patient's current medications include fentanyl patch, Actiq, Lyrica, Remeron, and Tizanidine. This patient has been prescribed Actiq for her chronic pain symptoms since at least 12/17/14. The treater states in the 03/11/15 report that medications help reduce pain level from 9/10 to 4/10. With medications, she is more functional with improved quality of life. MTUS does not support the use of Actiq for musculoskeletal pain. The request is not medically necessary.

Tizanidine 4mg #90: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 64-66.

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

Decision rationale: This patient presents with chronic back and right wrist pain. The current request is for Tizanidine 4mg #90. The Request for Authorization is not provided in the medical file. Previous treatments included physical therapy, spinal cord stimulator, psychological care and medications. The patient is not working. MTUS Chronic Pain Medical Treatment Guidelines for Muscle Relaxants for pain, pg. 66:" Antispasticity/Antispasmodic Drugs: Tizanidine (Zanaflex, generic available) is a centrally acting alpha2-adrenergic agonist that is FDA approved for management of spasticity; unlabeled use for low back pain. One study (conducted only in females) demonstrated a significant decrease in pain associated with chronic myofascial pain syndrome and the authors recommended its use as a first line option to treat myofascial pain." The patient has been utilizing Tizanidine since at least 12/17/14. The treater states in the 03/11/15 report that medications help reduce pain level from 9/10 to 4/10. With the use of medications, she is more functional with improvement in quality of life. MTUS supports the use of Tizanidine for low back pain. Given the patient's symptoms, diagnosis, and documentation of benefit, Tizanidine is appropriate. Therefore, the request is medically necessary.

Lumbar epidural steroid injection: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections Page(s): 45.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ESI Page(s): 46-47.

Decision rationale: This patient presents with chronic back and right wrist pain. The current request is for Lumbar epidural steroid injection. The Request for Authorization is not provided in the medical file. Previous treatments included physical therapy, spinal cord stimulator, psychological care and medications. The patient is not working. MTUS Chronic Pain Treatment Guidelines, section on Epidural steroid injections (ESIs) page 46 states Recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). The MTUS Criteria for the use of Epidural steroid injections states: "Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electro diagnostic testing," and 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. Physical examination on 03/11/15 revealed allodynia in the bilateral upper and lower extremities. There is weakness and pain during examination. Progress report 12/17/14 states that the patient complains of low back pain with radiating numbness into the bilateral lower extremities. The medical file provided no reference to an MRI of the lumbar spine or EMG/NCVs. In this case, an ESI cannot be considered as there is no MRI to corroborate the patient's radicular symptoms. MTUS states that radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electro diagnostic testing. This request does not meet guideline criteria; therefore, the request is not medically necessary.

Inpatient detoxification for 10 days: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Inpatient pain rehabilitation programs Page(s): 32.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Detoxification Page(s): 42. Decision based on Non-MTUS Citation Official disability guidelines Pain chapter, discusses detoxification.

Decision rationale: This patient presents with chronic back and right wrist pain. The current request is for Inpatient detoxification for 10 days. The Request for Authorization is not provided in the medical file. Previous treatments included physical therapy, spinal cord stimulator, psychological care and medications. The patient is not working. MTUS Guidelines, page 42, under the topic Detoxification, discusses detoxification and states it is recommended as indicated below. Detoxification is defined as withdrawing a person from a specific psychoactive substance, and it does not imply a diagnosis of addiction, abuse, or misuse. May be necessary due to the following: intolerable side effects, lack of response, aberrant behaviors as related to abuse and dependence, refractory comorbid psychiatric illness, or lack of functional improvement. Gradual weaning is recommended for long-term opiate users because opiates cannot be abruptly discontinued without probable risk of withdrawal symptoms. MTUS Guidelines do not discuss the duration or frequency of the program. However, ODG Guidelines,

under the Pain chapter, discusses detoxification and recommends a medium duration of 4 days. This patient's current medications include fentanyl patch, Actiq, Lyrica, Remeron, and Tizanidine. According to progress report 03/011/15, the patient reported lying down most of the day and is not participating in family function lately. The treater feels that the patient is at her lowest level and ability to wean on an outpatient basis. At this time, the patient is ready for inpatient detoxification program. Due to the patient's lack of functional improvement, a detox program may be considered. Therefore, the request is not medically necessary.