

<b>Case Number:</b>	CM15-0100612		
<b>Date Assigned:</b>	06/03/2015	<b>Date of Injury:</b>	10/06/2000
<b>Decision Date:</b>	07/08/2015	<b>UR Denial Date:</b>	04/29/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	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:

The injured worker is a 59 year old female, who sustained an industrial injury on October 6, 2000. The mechanism of injury was not provided. The injured worker has been treated for neck, back and right shoulder complaints. The diagnoses have included greater trochanteric bursitis, left shoulder impingement, bilateral sacroiliac joint dysfunction, lumbar segment degeneration, left lower extremity radiculopathy, disorders of sacrum, right acromioclavicular joint degenerative joint disease, scoliosis in other diseases and chronic intractable pain. Treatment to date has included medications, radiological studies, right shoulder computed tomography arthrogram, spinal cord stimulator implantation, physical therapy, ice treatments, revision of the spinal cord stimulator and a lumbar laminectomy. Current documentation dated April 7, 2015 notes that the injured worker reported low back, neck, right shoulder and bilateral leg pain. The pain was rated an eight out of ten on the visual analogue scale with medications. The pain was characterized as constant, sharp, dull, throbbing aching and pins and needles. Physical examination noted the injured worker to be in mild to moderate distress. Cervical spine examination revealed tenderness to palpation of the paraspinal muscles and a decreased range of motion. Examination of the low back revealed tenderness to palpation of the lumbar paraspinal muscles, decreased range of motion in all planes and a positive straight leg raise bilaterally. The injured worker was noted to be depressed with a flat affect. The treating physician's plan of care included requests for an Intrathecal pump trial with fluoroscopy, an Aleveer patch # 60, MS Contin15 mg # 60 and Robaxin 750 mg # 90.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **Intrathecal pump trial with fluoroscopy:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Implantable drug delivery systems.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Low back chapter: Implantable drug-delivery systems (IDDSs).

**Decision rationale:** According to the 04/07/2015 report, this patient presents with an 8/10 "Low back, Neck, bilateral leg, and shoulder pain." The patient is status post right shoulder Muniford Procedure on 04/02/2015. The current request is for Intrathecal pump trial with fluoroscopy. The request for authorization is on 04/20/2015. The patient's work status is permanent and stationary. MTUS and ACOEM Guidelines do not discuss intrathecal drug delivery systems. However, ODG Guidelines has the following in the pain section, which states, recommended only as an end-stage treatment alternative for selected patients for specific conditions after failure of at least 6 months of less invasive methods and following a successful temporary trial. Indications for implantable drug delivery system when it is used for the treatment of non-malignant pain with a duration of greater than six months and all of the following criteria are met: 1) Documentation in the medical records of failure of 6 months of other conservative treatment modalities, 2) Intractable pain secondary to a disease state with objective documentation of pathology, 3) Further surgical intervention or other treatment is not indicated, 4) Psychological lab evaluation had been obtained, 5) No contraindications to implantation, and 6) A temporary trial of spinal epidural or intrathecal opiates have been successful prior to permanent implantation with at least 50% to 70% reduction in pain. In this case, it appears the patient has failed medications and other conservative treatments. However, there were no psychological evaluation and no objective documentation of a disease state with objective documentation of pathology. The patient has meets some but not all of the ODG criteria for an IT pain pump trial. Therefore, the request IS NOT medically necessary.

### **Aleveer patch #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111-113.

**Decision rationale:** According to the 04/07/2015 report, this patient presents with an 8/10 "Low back, Neck, bilateral leg, and shoulder pain." The patient is status post right shoulder Muniford Procedure on 04/02/2015. The current request is for Aleveer patch #60; Aleveer patch contains 5% menthol and 0.0375 % Capsaicin. The request for authorization is on 04/20/2015. The patient's work status is permanent and stationary. Regarding Capsaicin, MTUS guidelines state there have been no studies of a 0.0375% formulation of capsaicin and there is no current

indication that this increase over a 0.025% formulation would provide any further efficacy. In this case, the requested 0.0375% formulation of capsaicin is not supported by the MTUS guidelines. The current request IS NOT medically necessary.

**MS Contin 15mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for chronic pain Page(s): 80-81.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines CRITERIA FOR USE OF OPIOIDS Page(s): 76-78, 88-89.

**Decision rationale:** According to the 04/07/2015 report, this patient presents with an 8/10 "Low back, Neck, bilateral leg, and shoulder pain." The patient is status post right shoulder Muniford Procedure on 04/02/2015. The current request is for MS Contin 15mg #60. This medication was first mentioned in this report; it is unknown exactly when the patient initially started taking this medication. The request for authorization is on 04//20/2015. The patient's work status is permanent and stationary. For chronic opiate use, MTUS Guidelines pages 88 and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4As; analgesia, ADLs, adverse side effects, and aberrant behavior, as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. Per the treating physician, the patient states "opioid medication is decreasing her pain level and improving her functioning. She denies any intolerable side effects. The patient understands to hold opioid medication upon sedation. She denies any diversion of medications or aberrant drug taking behaviors." In this case, the report shows documentation of pain assessment using a numerical scale describing the patient's pain ranging from 10/10 to an 8/10 with medication. Aberrant drug seeking behavior and adverse side effects were mentioned. However, there is no documentation as to how this medication is significantly improving the patient's ADL's and daily function. Outcomes measures are not documented as required by MTUS. No valid instruments are used to measure the patient's function which is recommended once at least every 6 months per MTUS. The treating physician has failed to clearly document the 4 As-analgesia, ADL's, adverse side effects, adverse behavior as required by the MTUS. Therefore, the request IS NOT medically necessary.

**Robaxin 750mg #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 65.

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

**Decision rationale:** According to the 04/07/2015 report, this patient presents with an 8/10 "Low back, Neck, bilateral leg, and shoulder pain." The patient is status post right shoulder Muniford Procedure on 04/02/2015. The current request is for Robaxin 750mg #90. The request for authorization is on 04//20/2015. The patient's work status is permanent and stationary. For muscle relaxants for pain, the MTUS Guidelines page 63 state "Recommended non-sedating muscle relaxants with caution as a second line option for short term treatment of acute exacerbation in patients with chronic LBP. Muscle relaxants may be effective in reducing pain and muscle tension and increasing mobility; however, in most LBP cases, they showed no benefit beyond NSAIDs and pain and overall improvement." A short course of muscle relaxant may be warranted for patient's reduction of pain and muscle spasms. Review of the available records indicate that this medication is has been prescribed longer then the recommended 2-3 weeks. The treating physician is requesting Robaxin #90 and it is unknown exactly when the patient initially started taking this medication. Robaxin is not recommended for long term use. The treater does not mention that this is for a short-term use to address a flare-up or an exacerbation. Therefore, the current request IS NOT medically necessary.