

Case Number:	CM15-0109582		
Date Assigned:	07/20/2015	Date of Injury:	05/07/2013
Decision Date:	09/15/2015	UR Denial Date:	06/02/2015
Priority:	Standard	Application Received:	06/08/2015

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: Georgia

Certification(s)/Specialty: Anesthesiology, Pain Management

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 50-year-old female, who sustained an industrial injury on 5/07/2013. Diagnoses include sacroiliitis of the bilateral sacroiliac joint, cervical sprain/strain status post cervical fusion and chronic pain. Treatment to date has included surgical intervention (cervical fusion undated) as well as conservative care including physical therapy, medications and bilateral sacroiliac joint injection x 2. Per the Primary Treating Physician's Progress Report dated 5/05/2015, the injured worker reported worsening of symptoms. She reports severe pain over the bilateral buttocks radiating to posterior and lateral aspect of the lateral thigh with numbness and tingling progressively increasing in severity. Physical examination revealed signs and symptoms of radiculitis/radiculopathy to the posterior and lateral aspect of the thigh. Gaenslen's test and Patrick Fabre test were positive. The plan of care included oral and compound topical medications, injections and transcutaneous neurostimulation and authorization was requested for one prescription of Flurbiprofen 25%/dextromethorphan 10% in Lidoderm base 180gm, one prescription of Ketoprofen 10%/Gabapentin 10%/Lidocaine 5%/Amitriptyline 5% in activemax base 180gm, 10 duragesic patches 25mg, Norco 10/325mg #60, Lyrica 100mg #60, one 3rd bilateral sacroiliac joint injection, one treatment of percutaneous neurostimulation and 4 permanent implantations of stimulator electrode array.

IMR ISSUES, DECISIONS AND RATIONALES

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

Flurbiprofen 25%, Dextromethorphan 10% in Lipoderm base 180 gm tube: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112.

Decision rationale: Flurbiprofen 25%, Dextromethorphan 10% in Lipoderm base 180 gm tube is not medically necessary. According to California MTUS, 2009, chronic pain, page 111 California MTUS guidelines does not cover "topical analgesics that are largely experimental in use with a few randomized controlled trials to determine efficacy or safety. Any compounded product that contains at least one drug or drug class that is not recommended, is not recommended". Per CA MTUS page 111 states that topical analgesics such as Flurbiprofen, is indicated for Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment. It is also recommended for short-term use (4-12 weeks). Additionally, Per CA MTUS page 111 states that topical analgesics are "recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (anti-depressants or AED)." Only FDA-approved products are currently recommended. Non-neuropathic pain: Not recommended. The claimant was not diagnosed with neuropathic pain and there is no documentation of physical findings or diagnostic imaging confirming the diagnosis; therefore, the compounded mixture is not medically necessary. The request was not specific as to what area the compound cream will be used. Additionally, there is little evidence to utilize topical NSAIDs and Lidocaine for treatment of pain associated with the spine, hip or shoulder; therefore, the compounded topical cream is not medically necessary.

Ketoprofen 10%, Gabapentin 10%, Lidocaine 5%, Amitriptyline 5% in acivemax base 180 mg tube: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112.

Decision rationale: Ketoprofen 10%, Gabapentin 10%, Lidocaine 5%, Amitriptyline 5% in acivemax base 180 gm tube is not medically necessary. According to California MTUS, 2009, chronic pain, page 111 California MTUS guidelines does not cover "topical analgesics that are largely experimental in use with a few randomized controlled trials to determine efficacy or safety. Any compounded product that contains at least one drug or drug class that is not recommended is not recommended". Per CA MTUS page 111 states that topical analgesics such as Ketoprofen, is indicated for Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment. It is also recommended for short-term use (4-12 weeks). Additionally, Per CA MTUS page 111 states that topical analgesics are "recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (anti-depressants or AED)." Only FDA-approved products are

currently recommended. Non-neuropathic pain: Not recommended. The claimant was not diagnosed with neuropathic pain and there is no documentation of physical findings or diagnostic imaging confirming the diagnosis; therefore, the compounded mixture is not medically necessary. The request was not specific as to what area the compound cream will be used. Additionally, there is little evidence to utilize topical NSAIDs and Lidocaine for treatment of pain associated with the spine, hip or shoulder; therefore, the compounded topical cream is not medically necessary.

Lyrica 100 mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-convulsants Page(s): 17-19.

Decision rationale: Lyrica 100mg #60 is not medically necessary. Per CA MTUS Pregabalin has been documented to be effective in treatment of diabetic neuropathy and postherpetic neuralgia, has FDA approval for both indications, and is considered first-line treatment for both. The claimant was not diagnosed with diabetic neuropathy or postherpetic neuralgia. There is also no documentation that the claimant has failed other first line AEDs; therefore, the request is not medically necessary.

Percutaneous neurostimulation/auricular electroacupuncture: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Spinal Cord Stimulation Page(s): 32.

Decision rationale: Percutaneous neurostimulator/auricular electropuncture is not medically necessary. Per CA MTUS spinal cord stimulator recommended only for selected patients in cases when less invasive procedures have failed or are contraindicated, for specific conditions indicated below, and following a successful temporary trial. Although there is limited evidence in favor of Spinal Cord Stimulators (SCS) for Failed Back Surgery Syndrome (FBSS) and Complex Regional Pain Syndrome (CRPS) Type I, more trials are needed to confirm whether SCS is an effective treatment for certain types of chronic pain. Indications for stimulator implantation: Failed back syndrome (persistent pain in patients who have undergone at least one previous back operation), more helpful for lower extremity than low back pain, although both stand to benefit, 40-60% success rate 5 years after surgery. It works best for neuropathic pain. Neurostimulation is generally considered ineffective in treating nociceptive pain. The procedure should be employed with more caution in the cervical region than in the thoracic or lumbar. Complex Regional Pain Syndrome (CRPS)/Reflex sympathetic dystrophy (RSD), 70- 90% success rate, at 14 to 41 months after surgery. (Note: This is a controversial diagnosis). Post amputation pain (phantom limb pain), 68% success rate, Post herpetic neuralgia, 90% success

Rate; Spinal cord injury dysesthesias (pain in lower extremities associated with spinal cord injury); Pain associated with multiple sclerosis, Peripheral vascular disease (insufficient blood flow to the lower extremity, causing pain and placing it at risk for amputation), 80% success at avoiding the need for amputation when the initial implant trial was successful. The data is also very strong for angina. (Flotte, 2004). Additionally, the guidelines indicate that the use of a spinal cord stimulator is a last resort when all other conservative attempts to control the patient's pain have failed, (for example, various medications including neuroleptics for neuropathic pain, injections, physical therapy.) There is lack of documentation of a psychology evaluation, successful spinal cord stimulator trial and given this is a treatment of last resort, there is a request for another interventional procedure of bilateral sacroiliac joint injections; therefore, the requested service is not medically necessary.

Four permanent implantations of stimulator electrode array: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Spinal Cord Stimulation Page(s): 32.

Decision rationale: Four permanent implantations of stimulator electrode array is not medically necessary. Per CA MTUS spinal cord stimulator recommended only for selected patients in cases when less invasive procedures have failed or are contraindicated, for specific conditions indicated below, and following a successful temporary trial. Although there is limited evidence in favor of Spinal Cord Stimulators (SCS) for Failed Back Surgery Syndrome (FBSS) and Complex Regional Pain Syndrome (CRPS) Type I, more trials are needed to confirm whether SCS is an effective treatment types of chronic pain. Indications for stimulator implantation: Failed back syndrome (persistent pain in patients who have undergone at least one previous back operation), more helpful for lower extremity than low back pain, although both stand to benefit, 40-60% success rate 5 years after surgery. It works best for neuropathic pain. Neurostimulation is generally considered ineffective in treating nociceptive pain. The procedure should be employed with more caution in the cervical region than in the thoracic or lumbar. Complex Regional Pain Syndrome (CRPS)/Reflex sympathetic dystrophy (RSD), 70- 90% success rate, at 14 to 41 months after surgery. (Note: This is a controversial diagnosis). Post amputation pain (phantom limb pain), 68% success rate, Post herpetic neuralgia, 90% success rate Spinal cord injury dysesthesias (pain in lower extremities associated with spinal cord injury); Pain associated with multiple sclerosis, Peripheral vascular disease (insufficient blood flow to the lower extremity, causing pain and placing it at risk for amputation), 80% success at avoiding the need for amputation when the initial implant trial was successful. The data is also very strong for angina. (Flotte, 2004). Additionally, the guidelines indicate that the use of a spinal cord stimulator is a last resort when all other conservative attempts to control the patient's pain have failed, (for example, various medications including neuroleptics for neuropathic pain, injections, physical therapy.) There is lack of documentation of a psychology evaluation, successful spinal cord stimulator trial and given this is a treatment of last resort, there is a request for another interventional procedure of bilateral sacroiliac joint injections; therefore, the requested service is not medically necessary.

