

<b>Case Number:</b>	CM15-0017639		
<b>Date Assigned:</b>	02/05/2015	<b>Date of Injury:</b>	03/19/2001
<b>Decision Date:</b>	04/01/2015	<b>UR Denial Date:</b>	01/21/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/29/2015

### 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 51-year-old female who reported injury on 03/19/2001. The injured worker underwent a spinal cord stimulator trial on 12/01/2014. The mechanism of injury was not provided. The documentation of 01/08/2015 revealed the injured worker had diagnoses that included cervicalgia and lumbago with bilateral radiculopathy, myofascial syndrome, cervicogenic headaches with intractable pain, reactive depression and anxiety, frequent falls, and second spinal cord stimulator trial of the lumbar spine. The documentation indicated the injured worker had full results, including a reduction of pain by approximately 75%, and a significant improvement in the functional status and ability to perform activities of daily living, decrease of approximately 50% of the use of Nucynta, and associated improvement in the injured worker's pain and sleep patterns. A request was made for a permanent placement of the spinal cord stimulator, plus 2 electrodes. The injured worker was utilizing Paxil for depression. The injured worker had improvements in mood with the use of Paxil. The physical examination revealed the injured worker had cervical muscle spasms along the course of the upper trapezius muscles bilaterally. The injured worker was tender over the rhomboids with multiple tender and trigger point areas. The injured worker had spasms into the neck, and cervicogenic headaches. The pain radiated into the bilateral upper extremities. The injured worker's medications were prescribed, which included Aciphex, Nucynta, Paxil, Terocin patches, and Restoril for sleep. There was a Request for Authorization submitted for review dated 02/02/2015. The original request for the spinal cord stimulator was dated 12/08/2014. The documentation indicated the injured worker had associated improvement in the general mood, as well as sleep. The injured

worker was better able to initiate and maintain a sleep pattern without the use of medication, and as such, the injured worker has significant improvement in the triad of findings that they were looking for in regards to a successful trial. The injured worker had significant decrease in pain, increase in function and activities of daily living, and decrease in medication use.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Flexeril 10mg: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine, Muscle Relaxants (for pain).

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

**Decision rationale:** The California Medical Treatment Utilization Schedule Guidelines recommend muscle relaxants as a second line option for the short term treatment of acute low back pain. There should be documentation of objective functional improvement, and the use is recommended for less than 3 weeks. The clinical documentation submitted for review indicated the injured worker utilized the medication for an extended duration of time. There was a lack of documentation of objective functional improvement and a decrease in muscle spasms with the use of the medication. The request as submitted failed to indicate the frequency and quantity of the medication being requested. Given the above, the request for prescription of Flexeril 10 mg is not medically necessary.

#### **30 Paxil 10mg: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 388, 402. Decision based on Non-MTUS Citation Official Disability Guidelines, Mental Illness & Stress, Paroxetine (Paxil).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants Page(s): 13.

**Decision rationale:** The California Medical Treatment Utilization Schedule Guidelines recommend antidepressants as a first line medication for the treatment of neuropathic pain, and they are recommended especially if the pain is accompanied by insomnia, anxiety, or depression. There should be documentation of an objective decrease in pain and objective improvement in function to include an assessment in the changes of the use of other analgesic medications, sleep quality and duration, and psychological assessments. The clinical documentation submitted for review indicated the injured worker had benefit of an improved mood. However, the specific documentation of an objective functional improvement, including the assessment in the changes of the use of other analgesic medication, sleep quality and duration, and psychological assessment was not provided. The request as submitted failed to indicate the frequency for the

requested medication. Given the above, the request for 30 Paxil 10 mg is not medically necessary.

**60 Restoril 15mg: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain (Chronic), Insomnia Treatment.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

**Decision rationale:** The California Medical Treatment Utilization Schedule Guidelines do not recommend the use of benzodiazepines for longer than 4 weeks due to the possibility of psychological and physiological dependence. The clinical documentation submitted for review indicated the injured worker had utilized the medication for an extended duration of time. There was a lack of documentation of exceptional factors to warrant nonadherence to guideline recommendations. Additionally, the request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Restoril 15 mg is not medically necessary.

**1 permanent Medtronic spinal cord stimulator w/2 electrodes: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Spinal Cord Stimulators (SCS), Indications for Stimulator Implantation.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Spinal Cord Stimulators, Spinal Cord Stimulator Page(s): 105, 106.

**Decision rationale:** The California Medical Treatment Utilization Schedule indicate that spinal cord stimulators are recommended only for selected patients in cases when less invasive procedures have failed or are contraindicated. It further Indicates that for stimulator implantation an injured worker should have the diagnosis of failed back syndrome with persistent pain in patients who have undergone at least one back surgery or patients who have the diagnosis of Complex Regional Pain Syndrome (CRPS)/Reflex sympathetic dystrophy (RSD). The clinical documentation submitted for review indicated the injured worker had a successful trial of the spinal cord stimulator. The injured worker had 75% pain reduction, significant improvement in functional status, and the ability to perform activities of daily living. However, there was a lack of documentation indicating the injured worker had a diagnosis of failed back syndrome or complex regional pain syndrome, spinal cord dysesthesia, pain associated with multiple sclerosis, post amputation pain, or postherpetic neuralgia. While it was noted the injured worker had a successful trial, the specific rationale for the use of the spinal cord stimulator was not provided. Given the above and lack of documentation, the request for 1 permanent Medtronic spinal cord stimulator with 2 electrodes is not medically necessary.