

Case Number:	CM15-0148242		
Date Assigned:	08/11/2015	Date of Injury:	04/17/1999
Decision Date:	09/23/2015	UR Denial Date:	06/30/2015
Priority:	Standard	Application Received:	07/30/2015

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 69 year old male who sustained an industrial injury on 4-17-1999. He was hurt when a conveyer belt crashed down on him developing back pain and lower extremity pain. He has reported lower back pain and has been diagnosed with lumbago and post lumbar fusion syndrome. Treatment has included surgery, medications, and injections. Gait was normal. Deep tendon reflexes were plus 1 bilaterally to the patellas and not elicited to the Achilles bilaterally. Sensation was decreased in dermatomes left L3, left L4, and left L5. Straight leg raise was negative. There was no spasm or guarding to the lumbar spine. The treatment plan included injection and medications. The treatment request included medications and SI joint injection.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ambien Controlled Release 6.25mg quantity 120: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Treatment in Workers' Compensation, Work Loss Data Institute, Pain, Zolpidem.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic) Chapter, under Zolpidem (Ambien).

Decision rationale: The current request is for Ambien Controlled Release 6.25mg quantity 120. The RFA is date 06/10/15. Treatment has included surgery (lumbar fusion 2001), physical therapy, medications, and injections. The patient is working. ODG-TWC, Pain (Chronic) Chapter, Zolpidem (Ambien) Section states: Zolpidem is a prescription short-acting non-benzodiazepine hypnotic, which is recommended for short-term (7-10 days) treatment of insomnia. Proper sleep hygiene is critical to the individual with chronic pain and often is hard to obtain. Various medications may provide short-term benefit. While sleeping pills, so-called minor tranquilizers, and anti-anxiety agents are commonly prescribed in chronic pain, pain specialists rarely, if ever, recommend them for long-term use. They can be habit-forming, and they may impair function and memory more than opioid pain relievers. There is also concern that they may increase pain and depression over the long-term. (Feinberg, 2008) Per report 06/10/15, the patient presents with lower back pain and has been diagnosed with lumbago and post lumbar fusion syndrome. Examination revealed deep tendon reflexes plus 1 bilaterally to the patella and not elicited to the Achilles bilaterally. Sensation was decreased in dermatomes left L3, left L4, and left L5 and straight leg raise was negative. The treater prescribed Ambien #30 plus 3 refills for the patient's insomnia. ODG recommends Ambien for short-term (7-10 days) treatment of insomnia, due to negative side effect profile. The request for quantity 30 in addition to the 3 refills does not indicate intended short-term use of this medication. The request is not in line with guideline indications. Therefore, the request IS NOT medically necessary.

Pantoprazole (Protonix) 20mg quantity 60: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Non Steroidal Anti Inflammatory Drugs Page(s): 68.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 69.

Decision rationale: The current request is for Pantoprazole (Protonix) 20mg quantity 60. The RFA is date 06/10/15. Treatment has included surgery (lumbar fusion 2001), physical therapy, medications, and injections. The patient is working. MTUS Chronic Pain Guidelines page 69 under NSAIDs, GI symptoms & cardiovascular risk Section states, "Clinicians should weight the indications for NSAIDs against both GI and cardiovascular risk factors. Determine if the patient is at risk for gastrointestinal events: (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA)." "Treatment of dyspepsia secondary to NSAID therapy: Stop the NSAID, switch to a different NSAID, or consider H2-receptor antagonists or a PPI." The treater states that the patient is using Ibuprofen which has the propensity to cause GI side effect. It was further noted that the use of Protonix has prevented GI side effects. The patient was also noted to have failed first line PPI (Prilosec) in the past. The patient has been taking ibuprofen on a long term basis and the treater states that Protonix has been effective in preventing GI upset. The request has been prescribed in accordance to MTUS. This request IS medically necessary.

Retrospective Oxycontin 40mg dispensed quantity 120: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 80-83;86;124.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for chronic pain CRITERIA FOR USE OF OPIOIDS Page(s): 60,61, 76-78, 88,89.

Decision rationale: The current request is for Retrospective Oxycontin 40mg dispensed quantity 120. The RFA is date 06/10/15. Treatment has included surgery (lumbar fusion 2001), physical therapy, medications, and injections. The patient is working. 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 adverse 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. MTUS page 77 states, "function should include social, physical, psychological, daily and work activities, and should be performed using a validated instrument or numerical rating scale." Per report 06/10/15, the patient presents with lower back pain and has been diagnosed with lumbago and post lumbar fusion syndrome. The treater is requesting a refill of medications. The patient has been prescribed Oxycontin and Norco concurrently since at least 02/15/15. The treater states that the patient is using Oxycontin for around the clock pain relief and Norco for break through pain. With the use of these medications, pain is reduced on average 8-9/10 to 4-5/10. He has improvement in ADLs including better tolerance walking, standing, bending and stooping. He works full-time as an in-home caretaker. UDS was conducted on 06/10/15 which was consistent and CURES report is dated 06/10/15. The patient has a signed pain contract dated 02/18/15. In this case, the 4A's have been addressed, and adequate documentation has been provided including numeric scales and functional measures that show significant improvement. The request appears to be in accordance with guidelines. Therefore, this request IS medically necessary.

Carisoprodol (Soma) 350mg quantity 45: Upheld

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

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

Decision rationale: The current request is for Carisoprodol (Soma) 350mg quantity 45. The RFA is date 06/10/15. Treatment has included surgery (lumbar fusion 2001), physical therapy, medications, and injections. The patient is working. MTUS Chronic Pain Guidelines under Muscle relaxants (for pain) pages 63-66 states Recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbation in patients with chronic LBP. The most commonly prescribed antispasmodic agents are Carisoprodol, cyclobenzaprine, metaxalone, and methocarbamol, but despite their popularity, skeletal muscle relaxants should not be the primary drug class of choice for musculoskeletal conditions. Cyclobenzaprine (Flexeril, Amrix, Fexmid, generic available): Recommended for a short course of therapy." MTUS, Chronic Pain Medication Guidelines, Muscle Relaxants, page 63-66: "Carisoprodol (Soma, Soprodal 350, Vanadom, generic available): Neither of these formulations is recommended for longer than a 2 to 3 week period." Abuse has been noted for sedative and

relaxant effects. The treater states that Soma reduces pain and the intensity of spasms. MTUS Guidelines supports the use of these types of muscle relaxants for short course of therapy, not longer than 2 to 3 weeks. The patient has been prescribed Soma since 02/10/15; therefore, recommendation for further use cannot be supported. This request IS NOT medically necessary.

Norco 10/325mg quantity 175: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 80-83; 86; 124.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for chronic pain CRITERIA FOR USE OF OPIOIDS Page(s): 60, 61, 76-78, 88,89.

Decision rationale: The current request is for Norco 10/325mg quantity 175. RFA is date 06/10/15. Treatment has included surgery (lumbar fusion 2001), physical therapy, medications, and injections. The patient is working. 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 adverse 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. MTUS page 77 states, "function should include social, physical, psychological, daily and work activities, and should be performed using a validated instrument or numerical rating scale." Per report 06/10/15, the patient presents with lower back pain and has been diagnosed with lumbago and post lumbar fusion syndrome. The treater is requesting a refill of medications. The patient has been prescribed Oxycontin and Norco concurrently since at least 02/15/15. The treater states that the patient is using Oxycontin for around the clock pain relief and Norco for break through pain. With the use of these medications, pain is reduced on average 8-9/10 to 4-5/10. He has improvement in ADLs including better tolerance walking, standing, bending and stooping. He works full-time as an in-home caretaker. UDS was conducted on 06/10/15 which was consistent and CURES report is dated 06/10/15. The patient has a signed pain contract dated 02/18/15. In this case, the 4A's have been addressed, and adequate documentation has been provided including numeric scales and functional measures that show significant improvement. The request appears to be in accordance with guidelines. Therefore, this request IS medically necessary

Retrospective Sacroiliac joint injection administered quantity 1: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Hip and Pelvis chapter, under SI joint therapeutic injection.

Decision rationale: The current request is for Retrospective Sacroiliac joint injection administered quantity 1. The RFA is date 06/10/15. Treatment has included surgery (lumbar fusion 2001), physical therapy, medications, and injections. The patient is working. The MTUS/ACOEM guidelines do not discuss SI joint injections. ODG guidelines were consulted. Official Disability Guidelines, Hip and Pelvis chapter, SI joint therapeutic injection: Not

recommend therapeutic sacroiliac intra-articular or periarticular injections for non-inflammatory sacroiliac pathology (based on insufficient evidence for support). Recommend on a case-by-case basis injections for inflammatory spondyloarthropathy (sacroiliitis). This is a condition that is generally considered rheumatologic in origin (classified as ankylosing spondylitis, psoriatic arthritis, reactive arthritis, arthritis associated with inflammatory bowel disease, and undifferentiated spondyloarthropathy). Instead of injections for non-inflammatory sacroiliac pathology, conservative treatment is recommended. Current research is minimal in terms of trials of any sort that support the use of therapeutic sacroiliac intra-articular or periarticular injections for non-inflammatory pathology. Below are current reviews on the topic and articles cited. There is some evidence of success of treatment with injections for inflammatory spondyloarthropathy, although most rheumatologists now utilize biologic treatments (anti-TNF and/or disease modifying antirheumatic drugs) for treatment. Per report 06/10/15, the patient presents with lower back pain and has been diagnosed with lumbago and post lumbar fusion syndrome. Examination revealed deep tendon reflexes plus 1 bilaterally to the patellas and not elicited to the Achilles bilaterally. Sensation was decreased in dermatomes left L3, left L4, and left L5 and straight leg raise was negative. The treater has requested a SI joint injection. ODG guidelines do not support such injections for this patient's chief complaint. Chronic pain is not considered by guidelines as an appropriate condition for such injections. ODG recommends SI joint injections on a case-by-case basis for conditions such as inflammatory spondyloarthropathy (sacroiliitis) or other rheumatological conditions. In this case, the patient presents with SI joint tenderness, but there is no indication that this pain is due to a rheumatologic in origin. Therefore, the request IS NOT medically necessary.