

Case Number:	CM15-0025393		
Date Assigned:	03/19/2015	Date of Injury:	06/30/2003
Decision Date:	04/17/2015	UR Denial Date:	01/22/2015
Priority:	Standard	Application Received:	02/10/2015

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: Texas, Florida, California

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

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 59 year old woman sustained an industrial injury on 6/30/2003. The mechanism of injury is not detailed. Current diagnoses include lumbar post-laminectomy syndrome, lower extremity neuropathy and radiculopathy, peripheral neuropathy, and indwelling permanent spinal cord stimulator. Treatment has included oral medications, surgical interventions, and insertion of permanent spinal cord stimulator. Physician notes dated 1/29/2015 show severe low back, buttock, and leg pain that is reported to be increased. The worker received trigger point injections and intramuscular injection of Demerol, Phenergan, and Toradol at this visit. Recommendations include radiofrequency ablation of facet nerves and medication refills. The physician notes that the worker does not require the medication dosages that she currently uses or the frequency of office visits for injections after the radiofrequency ablation procedures that she has received in the past and she has had relief after ablation for almost one year. Since this treatment has been denied, she has also had to visit urgent care centers for intervention.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Radiofrequency Ablation Lumbar Facet Nerves L3-4, L4-5: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300-1.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back section, under facet joint radiofrequency ablation.

Decision rationale: The current California web-based MTUS collection was reviewed in addressing this request. The guidelines are silent in regards to this request. Therefore, in accordance with state regulation, other evidence-based or mainstream peer-reviewed guidelines will be examined. Regarding facet joint radiofrequency ablation, the ODG guides note: Under study. Conflicting evidence is available as to the efficacy of this procedure and approval of treatment should be made on a case-by-case basis. Criteria for use of facet joint radiofrequency neurotomy: (1) Treatment requires a diagnosis of facet joint pain using a medial branch block as described above. See Facet joint diagnostic blocks (injections). (2) While repeat neurotomies may be required, they should not occur at an interval of less than 6 months from the first procedure. A neurotomy should not be repeated unless duration of relief from the first procedure is documented for at least 12 weeks at 50% relief. The current literature does not support that the procedure is successful without sustained pain relief (generally of at least 6 months duration). No more than 3 procedures should be performed in a year's period. In this case, although there has been reported benefit in the past, the percent improvement is not provided; relief is mentioned for one year, but no other information. There is no evidence of documentation of greater than or equal to 50% relief for long duration. Also, there are no facet signs documented on physical exam. There is no documented improvement in VAS score, specifics in regards to decreased medications, or functional improvements documented. The request is appropriately non-certified.

Fentanyl Patches 12.5mcg: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Low Back-Lumbar & Thoracic (Acute & Chronic).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 45 of 127 and page 88 of 127.

Decision rationale: Per the MTUS, this medicine is not recommended as a first-line therapy. Duragesic is the trade name of a fentanyl transdermal therapeutic system, which releases fentanyl, a potent opioid, slowly through the skin. The FDA-approved product labeling states that Duragesic is indicated in the management of chronic pain in patients who require continuous opioid analgesia for pain that cannot be managed by other means. In regards to the long-term use of opiates like Duragesic, the MTUS poses several analytical questions that simply have not been satisfactorily addressed in this case. These are: has the diagnosis changed, what other medications is the patient taking, are they effective, producing side effects, what treatments have been attempted since the use of opioids, and what is the documentation of pain and functional improvement and compare to baseline. These are important issues, and they have not been

addressed in this case. There especially is no documentation of functional improvement with the regimen. The request for long-term opiate usage via this patch is not certified per MTUS guideline review.

60 Topamax 50mg x 3: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 17 of 127.

Decision rationale: The MTUS notes that for chronic non-specific axial low back pain, a recent review has indicated that there is insufficient evidence to recommend for or against antiepileptic drugs for axial low back pain. (Chou, 2007) There was just one randomized controlled study that has investigated topiramate for chronic low back pain. (Muehlbacher, 2006) This study specifically stated that there were no other studies to evaluate the use of this medication for this condition. Patients in this study were excluded if they were taking opioids. No patient had undergone back surgery. So any conclusions out of such a limited population would not be generalizable for the workers compensation population as a whole, and specifically this claimant. Given the lack of study of this medicine for chronic pain, I would not support an incompletely studied medicine for the claimant. The request is appropriately non-certified.

90 Robaxin 500mg x 3: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 65 of 127.

Decision rationale: Methocarbamol (Robaxin, Relaxin, generic available): The mechanism of action is unknown, but appears to be related to central nervous system depressant effects with related sedative properties. This drug was approved by the FDA in 1957. The MTUS recommends non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP. (Chou, 2007) (Mens, 2005) (Van Tulder, 1998) (van Tulder, 2003) (van Tulder, 2006) (Schnitzer, 2004) (See, 2008) Muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in most low back pain, they show no benefit beyond NSAIDs in pain and overall improvement. Also there is no additional benefit shown in combination with NSAIDs. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. (Homik, 2004) In this claimant's case, there is no firm documentation of acute spasm that might benefit from the relaxant, or that its use is short term. Moreover, given there is no benefit over NSAIDs, it is not clear why over the counter NSAID medicine would not be sufficient. The request was appropriately non-certified under MTUS criteria.

30 Mirapex 0.25mg x 3: Upheld

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

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

Decision rationale: The current California web-based MTUS collection was reviewed in addressing this request. The guidelines are silent in regards to this request. Therefore, in accordance with state regulation, other evidence-based or mainstream peer-reviewed guidelines will be examined. The ODG mentioned the medicine as a pharmacologic option for the treatment of restless leg syndrome. There are four essential criteria for the condition (Allen, 2003) (1) An urge to move the legs, usually accompanied by uncomfortable and unpleasant sensations in the legs. Pain is often a primary component (reported as often as 50% of the time). Symptoms may involve the arms or other body parts. (2) The urge to move/unpleasant sensations become worse during periods of rest or inactivity. (3) Movement partially relieves the urge to move/unpleasant sensations (at least as long as the movement continues). & (4) The urge to move/unpleasant sensations are generally worse at night, or only occur at night. I did not see that this claimant met these criteria for the condition; therefore, the need for pharmacologic treatment for it is weak. Moreover, I did not see documentation of a trial with objective improvement out of the use of the medicine. Finally, the ODG also noted that Mirapex is a dopamine agonist; the generic is pramipexole. It notes these drugs are not considered first-line treatment and should be reserved for patients who have been unresponsive to other treatment. It is not clear what first line treatments had been tried and failed, and that the patient was responsive to other treatments. The request was appropriately non-certified under the evidence-based criteria.